Liability Insurance for California Long-Term Care Providers

A Report to the California Legislature

Governor Gray Davis
State of California

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Health and Human Services Agency

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Department of Health Services

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A C K N O W L E D G E M E N T S

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State agency representatives from various other states also provided information.

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EXECUTIVE SUMMARY

Pursuant to Section 53.5 of AB 430 (Chapter 171, St. of 2001), the State Department of Health Services shall convene a workgroup and shall submit a report to the appropriate committees of the Legislature, on the availability and cost trend for general liability and professional liability insurance for long term care providers in California.

DEPARTMENT OF HEALTH SERVICES (DHS) RECOMMENDATIONS

On any average day, approximately 100,000 Californians reside in **skilled nursing facilities (SNFs)** †, another 8,000 reside in intermediate care facilities for the developmentally disabled (ICF-DD, ICF-DD-H, or ICF-DD-N), and over 140,000 live in licensed residential care or assisted living facilities (see Table 1, page 4).

In the United States, "more than 12 million people, 6.6 million of whom are elderly, receive long-term care assistance," according to an April 2002 Issue Brief published by the Commonwealth Fund. [1] "Of elderly **long-term care (LTC)** recipients, 1.5 million reside in an institution such as a nursing home and the remainder receive care in their homes or communities."[2]

When Governor Davis took office in January 1999, concerns about staffing, quality, and the financial stability of nursing homes presented a cloudy picture for future LTC options. By 2020, nine million Californians will be over the age of 60, and it is important that a quality continuum of care is in place.

Almost immediately, the Governor determined that his Administration would establish a firm LTC policy base that would extend beyond a focus on nursing homes only. He began developing a multi-faceted, integrated strategy to improve California's LTC system, his **Aging with Dignity Initiative**. The initiative includes the principles that consumers need options and tools to make wise choices; caregivers need to be qualified and receive support and incentives to excel; and government must maintain a responsive framework to ensure the quality of services.

During this time, a related issue began affecting LTC providers. The insurance industry was increasingly unwilling to write liability insurance coverage, or at least at costs considered reasonable by providers. In the late '90s, Florida was the first State to experience serious problems related to the insurance industry's revised perception of the risks involved in the provision of LTC services.

† **Bold** is used to indicate the first time a term is used, definitions are provided in Appendix A.

In 1999, the House Committee on Elder Affairs and Long Term Care reported:

> Widespread concern was brought to the committee about the ill effects of inadequate direct care staffing in many Florida nursing homes. The number of lawsuits filed against facilities was increasing. Due to the increasing claims, the liability insurance companies began to choose between raising premiums and/or discontinuing the provision of liability coverage altogether.[3]

"Long-term care" focuses on managing on-going conditions over time. Services may include *medical assistance,* such as administering medication or performing rehabilitative therapy. But more typically it involves *personal care*, such as help with bathing and eating, and *supervision*, such as protecting a person from wandering away or inadvertently injuring themselves. The emphasis of long-term care is on enhancing a person's ability to function and enjoy a quality of life rather than on curing a condition."

Long Term Care: Providing Compassion without Confusion,
The Little Hoover Commission, December 1996, Pg. iii.

LTC "focuses on managing on-going conditions over time." [4] This basic definition is recognized by consumers seeking care and by organizations providing care. What has changed dramatically in the last several years, however, is "the rising case complexity in nursing facility admissions"[5], and the element of risk associated with the provision of LTC services.

Seventy percent of residents in SNFs are age 75 and older. For many, this is a temporary placement only—around 80 percent of residents are discharged within six months. However, those residents with serious or chronic health conditions may reside in a nursing home for several years. A SNF is not only a resident's health care provider; it is also that resident's home.

Risk is anything that prevents an organization from accomplishing its mission. Risk is the possibility of suffering harm or loss.[6] LTC providers, like any other residential business enterprise, purchase liability insurance to cover legal liability that might result from injuries to residents, others, or from damage to its property.

"Since 1997, the long-term care industry has faced an increasingly tight market for liability insurance coverage. As the number and size of liability cases against nursing homes grows, the cost of liability insurance policies continues to skyrocket."[7] There is no California State requirement that LTC facilities purchase liability insurance; but without such coverage, even one significant lawsuit could mean bankruptcy or closure.

What the insurance industry determined, through its **claims** experience, was that risk is greater for LTC providers than for other residential businesses. Media exposure of nursing homes, largely focusing on occurrences of abuse, neglect,

and inadequate staffing, combined with increasing **claims frequency** and **claims severity** trends, due to litigation, added to the negative risk perception.

Liability Insurance for California Long-Term Care Providers, A report to the California Legislature, responds to language that is part of the Governor's 2001-2002 Budget Act. While the majority of literature and information available on the subject pertains to nursing homes, liability insurance is an issue for any LTC housing where an element of risk exists. In addition to provider groups representing nursing homes, DHS also received comments regarding the issue of liability insurance from organizations representing ICF-DD facilities and those representing assisted living facilities. Consumer advocate, attorney, and insurer organizations also provided information.

In preparing the report, DHS found the data available regarding nursing home liability insurance are limited, and generate more questions than they provide answers. DHS does have data that indicate premiums are increasing and fewer companies are willing to write liability insurance policies for nursing homes. Frequency and size of claims are also increasing.

A myriad of factors affects cost and availability of liability insurance for LTC providers, and the report's organization identifies four inter-related areas:
- Nursing homes and the liability insurance market,
- Quality of care oversight and reimbursement,
- Enforcement and civil law, and
- Consumer access to quality LTC services.

DHS also has considered information on legislative and regulatory actions taken by other states to address the cost and availability of liability insurance. Insurance market changes occurred so recently, however, that data from other states are still limited, making it difficult to evaluate the effectiveness of changes that have been implemented to date.

The report analyzes and assesses 20 options for action that could affect the cost and availability of liability insurance for LTC providers, based on the literature and experience from other states (see Options for Consideration, pages 83-105). The final section of the report identifies five DHS recommendations for action.

RECOMMENDATIONS

1. Increase DHS data regarding litigation and insurance claims against nursing homes.
2. Increase DHS data regarding cost and availability of liability insurance.
3. Require nursing homes to implement an approved risk management plan as a condition of health facility licensure.
4. Conduct a study to assess the relationship between enforcement and legal actions in recent elder abuse cases.

5. DHS to work with the LTC Council to evaluate the broader implication of the affect of liability insurance issues on all LTC providers.

DHS recommendations focus on securing the information necessary for rational decision-making, and on supporting facility efforts to improve quality by strengthening facility system(s) to reduce losses.

The fact is that when losses do occur, organizations must pay for them somehow. Insurance is one of the many methods available for financing losses. However, insurance does nothing to prevent a loss from occurring. The least costly accident in terms of residents' and staffs' safety, time, money, and morale is the one that never happens.

Nursing Homes and the Liability Insurance Market

A nursing home in its effort to mitigate risk, like any other business, may purchase liability insurance to cover legal liability that might result from injuries to residents, or other persons, or from damage to its property. Such a liability insurance policy would pay for a claim that results from a court award or settlement.

A nursing home has four basic methods for securing coverage:

- A traditional policy through an **admitted insurance company** licensed in California;
- An excess or **surplus line** policy through an insurer not licensed in California;
- **Pooling arrangements** through an agreement where a group opts to share losses and expenses among members of the pool, typically with each paying a predetermined ratio; and
- **Self-insured**, an option mainly used by large organizations. A qualified self-insured is usually required to securitize the loss reserve through cash, letters of credit, and/or bonds.

Admitted companies are the only commercial insurance that must be registered and regulated by the state insurance agency.

A nursing home locates an insurance company to issue or write a liability policy. An insurance company writes a policy that, for a given premium, will cover:

- A defined amount of claims—the maximum coverage—including a designated dollar amount for the maximum coverage allowable for each claim, and a total dollar amount of coverage for all claims payments;
- A predetermined out-of-pocket responsibility of the insured for each claim—the deductible; and
- A specified period of time for the insurance coverage—policy term.

California nursing homes are not required to carry liability insurance or to send information to DHS regarding liability insurance claims filed, premiums paid, or type of coverage held. In May 2001, the California Department of Insurance

(CDI) inquired of the admitted insurers, licensed under its authority, to determine the state of LTC liability insurance availability for nursing homes and assisted living facilities in California between 1999 and 2000. The information was useful in preparing this report; however, it also revealed that only 13 percent of California nursing homes had policies with these state licensed insurers.

DHS also determined that Section 1305 of the Health and Safety (H&S) Code currently includes a requirement for liability insurers to report at least annually to DHS regarding claims activity against nursing homes. Insurers are to report any final judgment or settlement over $3,000 rendered against a facility for which they are providing liability insurance coverage. Although this language has been part of the H&S Code for 30 years, DHS found no documentation to indicate that the provision was implemented. The language in the H&S Code is similar to provisions in Section 801 of the Business and Professions (B&P) Code. That section requires every insurer providing professional liability insurance to physicians, to report to the California Board of Medical Quality. Insurers were to indicate any settlement awards over $3,000, or a claim or action for damages for death or personal injury caused by the physician's negligence, error or omission in practice or rendering of unauthorized professional services.

Several possible insurance market approaches exist that could be developed to assist LTC providers in securing liability insurance for their facilities. A state **joint underwriting association (JUA)** could be established to pool LTC liability insurance risk; CDI could investigate ways to expand the types of insurance companies with California licensure; or CDI could explore modifications to the rate structure for liability insurance. Several states are evaluating a JUA or other state sponsored risk pool. In 2001, Texas opened its JUA to for-profit nursing homes. Previously only non-profit facilities had access. To date, only a few facilities have chosen to use the Texas JUA for liability insurance.

Health and Safety Code, Section 1305. Insurers; report of judgments and settlements

(a) Every insurer providing professional liability insurance to a health facility licensed pursuant to this chapter and every health facility or associated group of health facilities licensed pursuant to this chapter under common ownership which are self insured shall report periodically, but in no event less than once each year, to the state department any final judgment over three thousand dollars ($3,000) rendered against such health facility during the preceding year of, a claim or action for damages for personal injuries caused by an error, omission, or negligence in the performance of its professional services, or by the performance of its professional services without consent.

(b) In the event that there are no final judgments or settlements in excess of three thousand dollars ($3,000) during the year such fact shall also be reported to the department. (Added by Stats. 1973).

Recommendation 1.
DHS, in consultation with CDI, the Medical Board of California, and OSHPD, will implement a system, effective January 2004, to notify all nursing homes, and liability insurance carriers, of the reporting requirements specified in Section 1305 of the Health and Safety Code (see Inset).

Implementation of this statute will provide useful data regarding final judgments or settlements over three thousand dollars rendered against a health facility and specified claims or actions for damages.

In addition, in October 2002, the Administration announced a consumer protection initiative to aid nursing home residents. One of its provisions required nursing homes to report all civil and criminal court actions filed against the facility to DHS.

Recommendation 2.
DHS, in consultation with CDI and OSHPD, will determine by December 2003, the need for a regulatory or statutory change to mandate that nursing homes provide specific basic information on liability insurance coverage, at the time of application for health facility licensure, and at the time of license renewal annually thereafter. The evaluation will utilize:

- CDI information secured from licensed or admitted insurers in the State (representing coverage for approximately 13 percent of nursing homes);
- OSHPD information secured under current financial reporting requirements for nursing homes;
- Information generated from a survey conducted by DHS, to be issued late 2003, of all nursing home owners regarding their current method of coverage and policy structure, including premiums, deductibles, and policy terms.

Quality of Care Oversight and Reimbursement

California is home to an array of LTC programs. A December 2000, Medi-Cal Policy Institute report, "The Role of Medi-Cal in California's LTC System," documented more than 74 public LTC programs and related services housed in six state agencies, with expenditures of at least $13.5 billion in 1998. Within those programs, what constitutes a long-term care facility also can vary depending on who uses the term and for what purpose.[8]

LTC is big business, and aging baby boomers will continue to make it a potential growth market. Many of the larger nursing facility and assisted living companies are publicly traded on the stock market. The nursing home industry currently comprises the largest part of LTC business, with national spending in 2000 of $92.2 billion.[9]

Nationwide, however, there is general dissatisfaction with the quality of care provided in nursing homes. According to a recent national survey:

> Majorities of the public believes that nursing homes are understaffed… that nursing home staff are often poorly trained, that at least some nursing home residents are abused and neglected, that many residents do not have enough privacy…and that many residents are lonely.[10]

Yet nursing homes are one of the most regulated of health care providers. A DHS Licensing and Certification (L&C) team of trained health professionals conducts an intensive **survey** of each California nursing home at least once every 9 to 15 months. The inspections average over 150 hours and include not only examination of administration and physical plant, but also an assessment of the quality and adequacy of the care. The survey team members review quality indicators based on patient assessment data, and observe, interview, and review medical records to determine compliance with federal and state requirements. Surveyors conduct onsite visits to investigate all **complaints** against nursing facilities. If there is an immediate and serious risk to a resident, the investigation will take place within 24 hours of the call.

Almost 15 years ago, the federal government established a framework to ensure the provision of quality services to nursing home residents whose care is paid for by the **Medicare** and **Medicaid** programs. Today, the **Center for Medicare and Medicaid Services (CMS)** continues to take additional steps to emphasize quality of care, outcome measurement, and empowerment of consumers through provision of detailed information from which to evaluate nursing home care.

The Davis Administration quickly perceived that to improve LTC in California, quality needed to be defined in broader terms, ones that also recognized the direct relationship between quality of care and the financial stability of the facility where care is being provided. Aging with Dignity, through legislation, the budget, and administrative actions, already has significantly strengthened the State's systems that oversee the provision of LTC services.

For example, multiple units are involved in oversight of nursing home payments, including DHS Medical Care Services (MCS), Electronic Data Systems (EDS), the fiscal intermediary contractor, OSHPD, and DHS Audits and Investigations (A&I). L&C involvement in reimbursement oversight had been limited, since its focus was licensing of nursing homes, compliance with federal and state quality standards, and enforcement actions against facilities. The passage of Administration sponsored legislation (AB 1075, Chapter 684, St. of 2001), requires a facility-specific rate-setting system that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities. L&C is now scheduling clinical reviews and financial audits to validate **Minimum Data Set (MDS**), or clinical data, submitted by nursing homes. These data are used for care planning, and are utilized by the federal government to assess patient

acuity and appropriateness of services provided. MDS will be considered in developing the facility specific rate methodology for Medi-Cal.

By further integrating performance and quality improvement into its nursing home oversight systems, Medicare and Medi-Cal will be providing information useful to evaluating positive performance of nursing homes in the area of quality and staffing.

Risk management and loss control, quality assurance, and compliance programs are all methods a nursing home may use to improve performance by correcting systemic issues and problems that increase the risk of a lawsuit or an enforcement action.

Risk management has been defined as the "process of planning, organizing and controlling the resources of an organization in order to minimize the adverse effects of accidental loss on that organization at the lowest possible cost." The typical steps involved in the process are:

- Identify potential loss-producing situations.
- Analyze and quantify loss exposures to determine the frequency and severity of exposure and the impact they will have upon the operation of the agency.
- Evaluate alternative methods of identifying and treating exposures. Methods include loss prevention (loss reduction) and financing through either self-funding or purchase of commercial insurance.
- Implement the chosen decisions.
- Monitor the performance of the chosen decisions and modify the program as necessary.

Risk Management Handbook, from Idaho Office of Insurance Management, Risk Management (1999).

"State of the Insurance Market," is published by the American Association of Homes and Services for the Aging (AAHSA), as a resource document for its members. The author, Sharon Fine of Aon/Huntington Block Insurance, identifies risk management and loss control as an important method for facilities to deal with the current insurance crisis.[11] The nature of the insurance industry is to gain predictability and consistency.

Consumer advocate, insurer, and provider organizations concur that risk management is crucial in efforts to improve the quality of care provided in nursing homes.

According to an article in the June 2001, California Advocates for Nursing Home Reform (CANHR) newsletter:

> Instead of spending millions of dollars to lobby Legislators to curtail the right of abuse victims, the nursing home industry should spend those dollars to establish a Risk Reduction Program and work with the insurance industry to identify high-risk facilities, intervene and provide technical assistance to improve facilities. Insurance companies always spread the risk of liability. Thus, a handful of high risk, frequently sued facilities or chains will increase premiums for all.[12]

California currently has no requirements that a nursing home establish a risk management program. The goal of a risk management program is to minimize

the cost of risk. It is an ongoing and active effort to identify hazards and prevent losses before they occur. An effective risk management program becomes an integral element in the organization's culture and part of the fabric of routine operations.

Recommendation 3
DHS will explore regulatory or statutory changes to require nursing homes to develop and implement a risk management plan that is approved by DHS as a condition of licensure. The requirements will identify the basic components that a facility's plan must include to comply. In general terms, the proposed risk management requirement is summarized below:

Structure

- Risk manager (full-time for a facility of 50 beds or more).
- Risk management committee with ongoing delegated authority to specific individuals for the day-to-day operation of a loss control program.
- Internal processes to provide organizational integrity and corporate compliance with all local, state, and federal laws and regulations.
- Training program for new employees and ongoing coordination of in-service training.

Basic Components

- Regularly planned risk assessments, to identify areas of risk in the facility.
- Risk management committee will develop the risk management plan. The risk information must be translated into decisions and mitigating actions.
- A plan for implementing corrective action, including establishing an early reporting and coordinated response procedure.
- A plan for tracking and evaluating the effectiveness and overall performance of the program.
- A program audit that includes a written plan to monitor and test safety and risk avoidance programs.
- A communication system that establishes a process for submitting suggestions or concerns to the risk manager or the risk management committee. A safety and risk avoidance manual describing the organization's structure and approach for maintaining a safe environment to be provided to staff, volunteer personnel, residents and family members.

Documentation

- Action plan and specific priorities for focused efforts of risk mitigation;
- Corporate compliance plan;
- Claims summary and trend analysis—trending should include evaluation of both claims frequency and severity;
- Required document check list; and
- Risk management committee minutes of meetings.

Required Reporting to DHS

- Risk management plan.
- Quarterly generated claims summary with the organization's trend analysis. Starting in 2006, DHS will publish industry benchmarks for risk management, identify industry trends in claims experience, with mean values as well as one and two standard deviation values.

DHS Technical Assistance

- To act as a resource to facilities requesting additional assistance with establishing their risk management programs, or in addressing risk mitigation in any one of the organization's focus areas.
- To act as a resource to liability insurance providers that have questions regarding the information available about LTC facilities that is generated by the regulatory oversight process.

Enforcement and Civil Law

The Medical Injury Compensation Reform Act (MICRA) of 1975 and the Elder Abuse & Dependent Adult Civil Protection Act (EDACPA) of 1991 form a strong foundation of civil law in California. These two Acts recognize the importance of health and safety considerations for all citizens, and the right of individuals, especially the elderly and dependent, to protection from abuse and neglect (see Appendix E).

MICRA prescribed parameters for civil actions against medical providers at a time when the Legislature determined that escalating malpractice insurance costs threatened access to medical treatment for Californians. The focus of MICRA in 1975 was physicians, but the definition of "health care provider" in the statute also included health facilities.

EDACPA provided enhanced remedies for elderly victims of abuse and neglect when the Legislature determined that without such special provisions, deserving individuals were systematically being denied cause of action under MICRA and other statutes.

Neither California provider organizations nor consumer advocates are arguing that provisions for MICRA or EDACPA should be eliminated entirely. Other states have focused on several basic areas of civil law in their effort to resolve problems with availability and cost of liability insurance:

- Pre-suit requirements to encourage parties to resolve the claim, if possible, before the case goes to court.
- Statute of limitations for cases to enable more predictability for facilities and insurers, reducing the number of cases that might come up from earlier time periods.
- Determination of reasonable attorneys' fees to enable more predictability for facilities and insurers regarding the costs associated with a claim/case.
- Modification of **punitive damages** requirements for elder abuse cases. Punitive damages "punish" the defendant for egregious, deliberate, or harmful

misconduct. Punitive damages normally are not insurable and are paid directly by the nursing homes. A punitive damage claim, however, also increases the overall amount for which an action may be resolved.

In California, consumer advocates and providers disagree about the causes for problems with availability and cost of liability insurance. Liability insurance, by definition, covers a facility's legal liability that might result from injuries to residents or others. Consumer advocates and attorneys believe that increases in the frequency and amount of settlements and awards in lawsuits against nursing homes reflect poor care being provided. "Insurance rates increase as risk increases among nursing homes that are not providing adequate quality of care."[13]

Providers believe that the prevalence of litigation is due to overly aggressive attorneys that actively solicit cases, encourage suits and inflate claims. Providers also do not see an "empirical relationship between facilities' experiences and the increased cost" of liability insurance.[14]

The State has little information on whether civil litigation against nursing homes is threatening consumer access to LTC options by creating problems of availability and cost of nursing home liability insurance. Implementation of **Recommendation 1** of this report (see page 4, Executive Summary, and page 105, Recommendations) should provide additional data on this subject, since it requires liability insurers to report specific claims, judgment and settlement information to DHS.

The State also has limited information to demonstrate that **civil actions** have improved quality of care in nursing homes. DHS conducts onsite inspections of licensed health facilities on a periodic basis, and in response to complaints filed by the public. At the completion of the inspection, surveyors prepare a report to the facility listing violations of various laws and regulations. The facility is then required to prepare a **Plan of Correction (POC).** After the POC is accepted, a follow-up visit can be scheduled to ensure that all needed corrective actions have been taken. The policy behind this process is straightforward—when problems are found in health facilities, those problems should be corrected as soon as possible.

DHS also works closely with the Bureau of Medi-Cal Fraud and Elder Abuse within the Office of the Attorney General on elder abuse cases. Whenever DHS receives a complaint that alleges abuse, neglect, or misappropriation of resident funds or property, DHS notifies and faxes a copy of the complaint to the Bureau. DHS continues to investigate the complaint and provides documentation and assistance should the Bureau decide to prosecute.

L&C inspection findings can be, and are currently used in civil litigation, particularly with respect to nursing homes. Neither the act of providing a POC, nor its contents or implementation, however, may be used in any legal

proceeding as an admission by the facility that the violation leading to the POC occurred. This is consistent with provisions in the Evidence Code to the effect that evidence of remedial conduct cannot be used to prove negligence or culpable conduct related to the event that caused the remedial action to be taken. The policy premise is to promote timely and appropriate remedial action. Current law does not absolutely prohibit admission of a POC into evidence, but the courts allow it only within the context of the Evidence Code.

If a case results in punitive damages, or in a significant settlement award, no analysis has been undertaken to assess the relationship of DHS enforcement actions, civil actions, and Bureau of Medi-Cal Fraud and Elder Abuse actions. More than anecdotal information is necessary if DHS is to recommend changes to the two acts that govern civil law for medical liability and elder abuse cases.

Recommendation 4.
DHS, in consultation with the Office of the Attorney General, Bureau of Medi-Cal Fraud and Elder Abuse, by January 2004, will complete a review of available elder abuse cases that resulted in settlements or punitive damages. The review will address court documents, DHS enforcement actions, performance indicators, and trend data preceding and following the civil action.

Consumer Access to LTC
Access is the freedom or ability to obtain or make use of LTC services. If a LTC provider loses or fails to maintain liability insurance coverage, it places the facility at risk of bankruptcy or financial insolvency should civil litigation be filed against it.

The responsibility of government in the LTC market is to ensure that high quality services are provided by facilities, through a system of licensing and regulatory oversight and enforcement. In the event that a regulated facility closes, government is responsible for ensuring the rights of the resident continue to be protected.

The majority of available information for this report focuses on the cost and availability of liability insurance for nursing homes. Escalating liability insurance costs and difficulties in coverage, however, affect the financial picture for all types of senior housing, such as ICF-DD facilities, and assisted living.

The California Health and Human Services Agency (CHHS) administers state and federal programs for health care, social services, public assistance, job training, and rehabilitation. Responsibility for administering the major programs that provide direct services to millions of Californians is divided among the agency's 15 boards and departments. For example, DHS and the Department of Social Services (DSS) are within CHHS. DHS has authority for licensing health facilities, while DSS is responsible for licensing Residential Care for the Elderly (RCFE) facilities that provide assisted living services.

Governor Davis signed legislation in 1999 to establish a Long-Term Care Council within CHHS. One of its main objectives was to create a framework to address issues collaboratively across state departments that affect quality and access to LTC.

Recommendation 5.
DHS will provide the LTC Council with the report, *Liability Insurance for California Long-Term Care Providers, A Report to the Legislature,* and provide any consultation necessary to assist the Council.

Further Considerations

What further complicates the provision of nursing home care, however, is the significant role government also plays as the major provider of funding. In California, Medi-Cal pays for over 51 percent of nursing home costs, and Medicare 17 percent. The total estimated Medi-Cal expenditure for fiscal year 2002-03 for nursing homes and ICF/DD facilities is $3.1 billion, or approximately 12 percent of all Medi-Cal expenditures.

Costs paid for by residents or their families through LTC insurance or other payers is growing, but is still a relatively small number, only 11 percent.

In order to support expanded use of LTC insurance, DHS established an innovative program, the **California Partnership for Long-Term Care**, in cooperation with a select number of private insurance companies. These companies offer high quality policies that must meet stringent requirements set by the Partnership and the State of California. The Partnership LTC insurance not only pays out benefits when required, it also seeks to protect the policy holders from having to spend down assets, and it seeks to protect those assets from Medi-Cal estate recovery.

As one method to ensure an adequate LTC continuum in the future, California, and the federal government will continue to focus on expanding the use of LTC insurance to improve access to LTC services:

> A revenue source in its infancy, long-term care insurance generates a very small portion of nursing facility revenue. Very few aging Americans buy private long-term care insurance and when they do it is often initiated at an advanced age—defeating the purpose of the insurance design. Inevitably, unless this trend is reversed, likely through changes in tax policy, the growing financing burden will remain on the taxpayer base and present rapidly increasing fiscal pressure on the public programs—Medicare and Medicaid.[15]

Implications

LTC providers, like any residential businesses, purchase liability insurance as part of their overall risk management plans. Without such coverage, even one significant lawsuit could mean bankruptcy or closure.

On the other hand, when a lawsuit is filed against a LTC provider, that action may represent a serious issue, directly related to poor resident care. That action could reflect that current oversight, regulation, and enforcement were not sufficient to ensure resident safety.

Promoting a continuum of high quality LTC services for California's elderly and disabled is a major principle of the Governor's Aging with Dignity Initiative. Provision of care, however, is a consumer service and a business enterprise. There are no "quick fixes." Solutions must always consider quality outcomes, impact on business operations, and access to care.

[1] Juliette Cubanski and Janet Kline, "In Pursuit of Long-Term Care: Ensuring Access, Coverage, Quality," an *Issue Brief*, The Commonwealth Fund, April 2002, p. 1. www.cmwf.org.
[2] Ibid.
[3] Florida House of Representatives, *Final Report: Select Committee on Liability Insurance for Long Term Care Facilities*, March 15, 2002, p. 6.
[4] Little Hoover Commission, *Long Term Care: Providing Compassion without Confusion,* Sacramento, CA, December 1996, p. iii.
[5] Tom Scully, "Health Care Industry Market Update Nursing Facilities," CMS, February 6, 2002, p. 6, www.cms.gov.
[6] The Continuing Care Accreditation Commission in Sharon Fine, AON/Huntington Block Insurance for the *American Association of Homes and Services for the Aging,* "State of the Insurance Market," p. 8.
[7] Elizabeth Devore, "Nursing Homes: The Escalating Liability Crisis," National Conference of State Legislatures (NCSL) Tracking Service, February 2002, p. 1.
[8] Charlene Harrington, *The Role of Medi-Cal in California's Long-Term Care System*, Medi-Cal Policy Institute, San Francisco, CA, December 2000, p. 1.
[9] Scully, op.cit.
[10] The Health Unit, *National Survey on Nursing Homes, Highlights and Chartpack*, The NewsHour with Jim Lehrer/Kaiser Family Foundation/Harvard School of Public Health, October 2001, p. 1. www.kff.org.
[11] Fine, op.cit., p. 4.
[12] CAHNR's Legal Network News—June 2001, p. 6. www.canhr.org.
[13] Rob Cartwright, Jr., Testimony before the California Legislature, Joint Informational Hearing on "Nursing Home Closures, Bankruptcies and Liability Insurance: Is There a Crisis?" on March 6, 2002.
[14] Anne Burns Johnson, Testimony before the California Legislature, Joint Informational Hearing on "Nursing Home Closures, Bankruptcies and Liability Insurance: Is There a Crisis?" on March 6, 2002.
[15] Scully, op.cit., page 18.

I. BACKGROUND

The **long-term care (LTC)** † industry has grown increasingly concerned in the last few years with problems related to the availability and cost of liability insurance for its facilities. Liability insurance covers the policyholder's legal liability resulting from injuries to other persons or damage to their property. LTC providers, like other businesses, decide whether to carry liability insurance as part of their overall risk management plans.

In the late '90s, a number of highly publicized lawsuits in Florida resulted in high jury awards and settlements. Soon Florida LTC facilities were experiencing sharp increases in their liability premiums. Some insurance carriers (and some nursing home companies) left that State altogether. Providers in other States, including California, began to see significant increases in premiums.

MANDATE

> "Ruth Kilduff, Senior Vice President, MARSH, Inc., set the stage for understanding the liability crisis by examining the current climate in long-term care. A confluence of events have led the insurers to reexamine their risks: the fragmentation of families leaving elders alone, the ongoing growth in the numbers of frail Americans, and the growing disparity between the value of caring for our elderly and the pay of those who provide the care. In addition, insurance carriers…missed the boat when they failed to observe the increasing liability risks in long-term care settings; they were insuring real estate values, not liability risk."
>
> –B.C. Ziegler and Company's Senior Living Finance Group (6/1/01)

Assembly Bill 430, the Health Budget Trailer Bill for 2001-2002, effective July 1, 2001, included a provision for the Department of Health Services (DHS) to convene a workgroup to review the issue of liability insurance coverage for long-term care providers and report its findings to the Legislature (See Appendix B). The report is to address issues relating to the availability and cost of general liability and professional liability insurance for long-term care providers in California.

The term "long-term care provider" or LTC is not defined in the legislation, and Table 1 on page four identifies several definitions. The majority of information on the subject relates

† **Bold** is used to indicate the first time a term is used, definitions are provided in Appendix A.

to **Skilled Nursing Facilities (SNFs)**, although liability insurance is an issue for any LTC housing where an element of risk exists.

This report approaches the mandate by reviewing:

- The role of the insurance industry in providing liability insurance to LTC providers;
- Existing data on the availability and cost trends for LTC providers in California;
- The national dialogue regarding availability and cost trends;
- Policy issues affecting the availability and cost trends for general and professional liability insurance;
- Recent actions in other states to address availability and cost of general and professional liability insurance; and
- Potential legislative or administrative options including an assessment of advantages and disadvantages.

The report includes:

Executive Summary.

I. Background. The purpose and organization of the materials.

II. Nursing Homes and the Liability Insurance Market. Liability insurance options for nursing homes, data on cost and availability of liability insurance and relevant factors affecting the insurance industry.

III. Quality of Care Oversight and Reimbursement. Basic regulatory and reimbursement factors affecting the cost and availability of liability insurance for nursing homes.

IV. Enforcement and Civil Law. Medical malpractice law, elder abuse law, Medicare/Medicaid fraud and abuse law, and legal enforcement remedies affecting the cost and availability of liability insurance for nursing homes.

V. Consumer Access to Quality Long-Term Care. Affect of liability insurance issues on consumers needing LTC services.

VI. Liability Insurance Issues in Other States. Legislative and regulatory actions in other states addressing the cost and availability of liability insurance for nursing homes.

VII. Options for Consideration. Potential administrative and legislative options for California related to the cost and availability of liability insurance.

VIII. Recommendations.

SOURCES OF DATA

The findings and recommendations presented are based on the following sources:

- Materials submitted upon invitation from identified stakeholders (see Acknowledgements and Appendix C).
- Selected reports and articles that identify or describe the policy and financial issues contributing to current trends (see Appendix D).
- Financial and utilization data on nursing homes from the Office of Statewide Health Planning and Development (OSHPD).
- Information compiled by the California Department of Insurance (CDI), including the results from a data call to determine the availability status of the long-term care "liability" insurance for nursing homes and assisted living facilities in California.
- Data from the Licensing and Certification Program Automated Certification and Licensing Administrative Information System (ACLAIMS) and the federal On-line Survey Certification and Reporting System (OSCAR).
- Medi-Cal Program cost data.

TABLE 1.

DEFINITIONS OF LONG-TERM CARE

A summary list of long-term care "facility" definitions is included below. Data regarding long-term care providers may vary according to the long-term care definition upon which they were based.

Term	Authority	Purpose	Definition
Long-Term Care Facility Services	Federal Medicare/Medicaid 42 Code of Federal Regulations (CFR) Section 447.251	Reimbursement	Nursing Facility (NF) Services (42 CFR 440.155) and Intermediate Care Facility Services for the mentally retarded (ICF/MR). ICF/MR are of varying bed sizes, but basically provide 24 hour care, habilitation, developmental and supportive health services to clients whose primary need is developmental services, and who have a recurring, but intermittent need for skilled nursing services (42 CFR 440.150).
Long-Term Care Health Facilities	State Department of Health Services (DHS) Section 1418 of the Health and Safety (H&S) Code	Health Facility Licensing	Facilities equivalent to federal definition: ☞ Skilled Nursing Facility (SNF) or "nursing home" (H&S 1250 (c)) ☞ Intermediate Care Facility (ICF) (H&S 1250 (d)) ☞ General Acute Care Hospital, distinct part SNF (DP/SNF) (H&S 1418) ☞ ICF-Developmentally Disabled (ICF-DD) (H&S 1250 (g)) ☞ ICF-DD Habilitative (ICF-DD-H) (H&S 1250 (e)) ☞ ICF-DD Nursing (ICF-DD-N) (H&S 1250 (h)) Plus ☞ Congregate Living Health Facility (CLHF) (H&S 1250 (I)) ☞ Pediatric Day Health Respite Care (PDHRC) Facility (H&S 1760.2) These two types are not eligible for federal funding, except in some Medi-Cal waiver situations.
Residential Care Facilities For The Elderly (RCFE) Assisted Living	State Department of Social Services (DSS) Section 1569.2 (k), H&S Code	Community Care Licensing	Facilities that provide care, supervision and assistance with activities of daily living, such as bathing and grooming. They may also provide incidental medical services under special care plans. These facilities are not eligible for federal Medicare/Medicaid funding, except under the Medi-Cal waiver being developed pursuant to Assembly Bill 499 (Aroner, Chapter 557, St. of 2000)
Continuing Care Retirement Communities (CCRC)	State DSS Section 1771(c)(8), H&S Code	Community Care Licensing	An agreement between a person 60 years or older and a continuing care provider. The contract includes a promise to provide a range of services at a CCRC for a period longer than one year in exchange for payment.

II. NURSING HOMES AND THE LIABILITY INSURANCE MARKET

*The data available regarding nursing home liability insurance coverage are limited and generate more questions than they provide answers. Nursing homes are not required to carry liability insurance or to send information to DHS regarding liability insurance **claims** filed, premiums paid, or type of coverage held. It is not possible to predict statewide trends without complete information on the status of liability insurance premiums and claims in the State.*

DHS does have some data that indicate premiums are increasing and fewer companies are willing to write liability insurance policies for nursing homes. Available data indicates frequency and size of claims are also increasing.

"The long-term care industry has rapidly morphed itself to meet consumer demands, and underwriters who were pricing this business based on a real estate model are now pricing it on an acute care model."

–Ruth Kilduff, Senior Vice-President, Marsh USA Inc.

Skilled nursing facilities are both a type of housing unit and a provider of health care. In seeking insurance coverage, a nursing home will purchase a policy covering both **professional** and **general liability**. General liability insurance addresses the risk from accidents occurring on the property. Professional liability addresses the occurrences of "errors and omissions" on behalf of the employees, that the employer—the skilled nursing facility—could be held responsible for. Professional liability insurance is a form of **malpractice insurance.**

Historically, insurance companies regarded nursing homes as a low risk for liability claims; the residents had minimal income and the exposure to litigation was limited. Financial and business communities viewed nursing homes as "properties" since they are a type of living arrangement. Financial transactions were decided based on factors such as stock prices, capitalization rates, investment potential, occupancy rates, and profitability ratios.

At the same time, the population of a nursing home is typically over 75 years of age, and residents are very ill, very frail, and often disoriented. The residents are in a nursing home for the purpose of continuous access to skilled care. The focus on the quality of care provided by

these residences has shifted the business sector's view of skilled nursing facilities. Wall Street transactions for publicly traded nursing home chains have become highly reactive to policy changes by the **Center for Medicare and Medicaid Services (CMS)** and trends in residence rights actions.

THE PROCESS

There is neither a state nor federal requirement for skilled nursing facilities to carry liability insurance.

Skilled nursing facilities are not in a position that risk can be eliminated; however, a well-structured risk management plan is designed to assess where there is exposure to risk and respond appropriately. "Risk is anything that prevents an organization from accomplishing its mission. Risk is the possibility of suffering harm or loss. A factor, element or course involving uncertain danger or hazard, especially catastrophic events."[1]

As part of its **risk management** plan, the nursing home, like any other business, may purchase liability insurance to cover its legal liability that might result from injuries to residents, or others, or from damage to its property. Such a liability policy would pay for a claim that results from a court award or settlement. In the case of an accident, the insurance company may offer payment for medical bills or other expenses as "settlement" for the claim. A claim filed for a legal action would cover the case's applicable defense costs and awarded **damages**. Some policies will cover **punitive damages**, if awarded by the jury. The insurer pays the coverage amount, less the out-of-pocket deductible. Without such coverage, just one significant lawsuit could mean bankruptcy or closure.

A nursing home locates an insurance company to issue or write a liability policy. The facility might utilize a **broker** or marketing specialist to deal with either agents or companies in arranging for the coverage. An insurance company will ask a nursing home a variety of questions during the course of evaluating a potential insured. The answers to the questions will determine how the insurer **underwrites** the policy. The **underwriter** will decide whether or not the insurance company should accept the applicant, and what amounts or terms the insurance company will set for accepting the risk. During this process, the insurance company may evaluate the physical condition of the facility and grounds, safety procedures and safety devices, any claims filed against the facility, and management of residents' care. The insurance company may also evaluate the management structure for mitigating the exposure of risk. Ideally, risk management is in the form of a comprehensive, multi-faceted risk management program with continuous monitoring and review of risk exposure and opportunities for risk mitigation. Such a program will also include a committee structure designed to address the occurrences of an incident or the near occurrence, and include a communication and grievance procedure to address resident and family complaints or concerns.

Structure of the Insurance Policy

An insurance company writes a policy that, for a given premium, will cover: (1) a defined amount of claims—the maximum coverage—including a designated dollar amount for the maximum coverage allowable for each claim, and a total dollar amount of coverage for all claims payments; (2) a predetermined out-of-pocket responsibility of the insured for each claim—the deductible; (3) a specified period of time for the insurance coverage—policy term. The policy will also specify when the incident may occur, during the policy term, for the claim to be eligible for coverage. An **occurrence** policy covers claims arising out of occurrences that take place during the policy period, regardless of when the claim is filed. A **claims-made** policy only covers claims filed during the policy period. For example, if a patient falls in December 2001 and the SNF files a claim in February 2002, an occurrence policy written for calendar year 2001 would provide coverage for the claim. However, a claims-made policy—that is written for calendar year 2002—would not cover the 2001 claim. A claims-made policy can be less risky for the insurance company, and less costly for the SNF. The exposure to a claim is defined and limited; the insurance company's risk is reduced, and consequently it tends to carry a lower premium than an occurrence policy. But, a claims-made policy carries a greater level of risk for the SNF.

Nursing homes that cannot find a liability insurance carrier to write a policy for them, or cannot afford the premium amount, may choose to operate without liability insurance—known as "**going bare."** Many reports indicate that some nursing homes have announced that they are not insured for liability claims, in efforts to stave off frivolous lawsuits. Nevertheless, a facility that has "gone bare" faces the greatest financial risk, should a lawsuit be filed.

A claim against a liability insurance policy, by definition, implies that in some manner the action of the nursing home was inadequate for a given situation. This fact tends to be a source of tension between the insurer and the nursing homes in regards to how a claim should be handled. The insurers are motivated toward cost containment and predictability. A nursing home has their reputation and the reputations of their staff on the line for each one of these claims.

Currently, some SNFs are choosing to **self-insure**, insure with a large deductible, or go bare, for the purpose of gaining more control over the potential response to a claim or lawsuit. In this way, a facility will focus its risk management efforts towards mitigation of claims exposure and set the facility claims **reserves** or **loss reserve** based upon the facility's specific assessment of loss exposure. The facility might be more likely to challenge a claim in court if their assessment of the incident is that the facility is not at fault. The facility's motivation in claims disposition differs from that of an insurer. A facility that opts not to utilize a commercial insurer will ultimately determine the handling of an incident or a claim.

The fact remains that when losses do occur, organizations must pay for them somehow. Insurance is one of many methods available for financing losses. However, insurance does nothing to prevent a loss from occurring. The least costly accident in terms of safety, time, money and morale is the one that never happens.

Coverage Options

Numerous liability insurance options are available to a nursing home, depending on its circumstances. Basically, the choices are: traditional or **admitted policy**; excess or **surplus line** policy; **pooling arrangement**; and, self-insurance (see Table 2, page 9 and Table 3, page 24 for more detailed information).

Admitted Carriers

The first option for coverage is usually the admitted carrier, which covers the more traditional forms of insurance. From the perspective of the SNF, if the insurance company experiences financial distress, the regulatory agency—CDI—can intervene and provide protection. Admitted insurers are the only type of insurance or insurance carrier that CDI regulates. When a line of insurance becomes too risky or too cost prohibitive for traditional insurers to carry, alternative forms of insurance coverage will often be developed.

Alternative to the Admitted Insurer

If an insurance broker is unable to find coverage through an admitted insurer, or if the terms of the policy are unattractive, the broker can look to place the policy with an alternative underwriter, typically a surplus line. An array of pooling arrangements and self-funded insurance options also exist (see Table 3, page 24). A choice among these options would depend upon the availability of the products and the size of the organization. These options meet various state or federal standards and may or may not be regulated by a state department of insurance.

Reinsurers

Underlying all the insurance options is one consistent thread. The insurance carrier, insurance pool, or the self-insured entity, will go to a **reinsurer** to insure its risk exposure. The reinsurance industry is the “insurance company” for the insurance companies. The typical reinsurer is a multinational conglomerate that is unregulated by the state insurance agencies.

The reinsurer will review the insurance carrier’s underwriting and choose to “endorse” the policies and set a price (premium) for the exposure the reinsurer will assume. Reinsurers are analyzed by rating agencies and therefore have an incentive to show a fiscally strong operation with stability being the key criteria for a positive rating (see insert page 18).

TABLE 2.

Who are the insurers in the market?

Admitted Carrier

The "traditional" insurance company registered and regulated by the state insurance agency. From the perspective of the SNF, if the insurance company experiences financial distress, the regulatory agency—CDI—can intervene and provide protection. Policies are typically purchased through an insurance agent or broker. Currently, this market is experiencing large consolidations as fewer, bigger players are making up this segment of the business. This is a cyclical trend in the insurance industry, indicative of a **"hardening"** of the market or a more difficult competitive environment.

Excess and surplus lines companies

Non-admitted insurance companies.

As the insurance market is responding to more difficult competitive conditions, the standard insurers will retract their lines of business and focus on the core product lines. The "miscellaneous" lines of insurance then shift to the excess and surplus line companies. The migration of business into the surplus lines market is largely attributed to a reduction in capacity from the standard market and, to a lesser extent, increasing pressure from reinsurers. [τ]

As the market is shifting over to surplus lines of coverage, less rate data are available. Excess and surplus insurers are not regulated by the CDI.

Reinsurers

Reinsurers are the insurance companies for the insurance carriers. The reinsurer supports the primary insurers and assists the insurers in the ability to spread risk. The reinsurer will review the primary insurers' underwriting guidelines and choose to "endorse" the product lines. The reinsurer will establish a deductible, known as an **attachment point**, at which dollar level of losses the reinsurer will assume any additional liability. Or the reinsurer will take a group of policies, to write on a "**cessions**" basis where the insurer will cede risk for the group of policies, or "layer" of coverage, and pass the risk to the reinsurer. The reinsurer will collect a percentage of premiums for an endorsement or will collect the full premium for a cession.

The reinsurance industry is an unregulated entity. The reinsurers are analyzed by rating agencies, such as Standard & Poor's and A.M. Best. These organizations will rate admitted, excess, and surplus insurers, as well other insurance vehicles. (See insert, page 18).

[τ] David Pilla "Surplus Lines Thrive in Post-Sept. 11 Market," *BestWire Service*, A.M. Best's, January 28, 2002.

FACTORS LIMITING CHOICE FOR NURSING HOMES

Some facilities do not have many insurance options outside of paying the admitted insurer the asked premium. Bond covenants or loan agreements—the conditions that the borrower accepts as terms of their debt obligation—may require that the facility maintain liability insurance. Some debt relationships may even require that the carrier be considered A-rated by the insurance rating agencies. The insurance company also may be unwilling to provide coverage, or will limit the terms of coverage, because a facility has previously demonstrated poor performance or has had an insurance claims history.

Once a relationship is established with an insurance company, the insurer is a determining factor in how claims are handled. Often if a lawsuit is filed against the insured, the insurance company will pursue a settlement of the lawsuit or claim, in lieu of a trial or as a cap on the potential jury award. In this way, the insurance company limits the potential size of the claims. However, the SNFs may be concerned that they have not had the opportunity to challenge the lawsuit, since it reflects on the quality of care provided in the facility.

LIABILITY INSURANCE TREND

Admitted Insurers

It is difficult to gather measurable statistics to define the trend in the insurance marketplace. Admitted insurers are the only insurance carriers that CDI regulates. These are also the only entities that the CDI can compel to report premium data or, in other words, are under agreement to participate in agency "data calls." When an insurance segment is experiencing volatility, identifying trends and statistics becomes more difficult. Insurance coverage will start to shift among carriers as certain insurers withdraw from the marketplace and other forms of insurance become comparably more attractive.

Trend Data From CDI Data Call

40 percent average premium increase between 1999 and 2000.

In May 2001, the CDI conducted a data call to determine the state of long-term care liability insurance availability for nursing homes and assisted living facilities in California. A circular was mailed to the 448 companies licensed to write commercial multi-peril and other liability insurance coverage. Thirty-three companies responded noting any experience for the period of 1997 to 2001. Of those, only 21 licensed insurers indicated they were currently writing LTC liability insurance in 2001, four of which indicated that they offered renewal policies only. This meant that only 18 admitted insurers, representing 13 groups/companies, were accepting new business in 2001. Twelve other companies that responded had stopped writing during the five-year period. Reasons for discontinuing coverage included: profitability,

reinsurance, huge losses, and lack of underwriting expertise. Between 1999 and 2000, a 40 percent increase in the average premium per policy was reported. The average monthly premium per facility was $9,794.

FIGURE 1.

California Long-Term Care Liability Insurance
All Provider Types

Year	Number of groups/insurers (In parentheses are the number of insurers)	Written Premium	**Earned Premium**	Policies Earned	Number of Facilities Covered*	Average Premium per Policy ($)	Average Premium per Facility ($)	Claims Incurred	Incurred Losses	**Loss Ratio**
1997	14 (26)	9,833,448	8,220,369	1,746	2,083	4,707	3,946	310	17,780,746	216%
1998	14 (26)	9,334,387	10,255,534	1,880	1,947	5,455	5,267	409	21,358,800	211%
1999	18 (28)	11,742,554	11,352,628	1,535	1,503	7,396	7,553	409	19,959,021	176%
2000	17 (25)	7,669,954	8,266,068	801	844	10,320	9,794	261	8,843,103	107%
2001**	13 (21)	NA	NA	NA	NA	NA	NA	NA	NA	NA

* Unable to provide complete data for the number of facilities covered. Some insurers were unable to provide a complete count of number of facilities.
**2001 premium and loss information was not available at the time the study was conducted.

Source: California Department of Insurance.

CDI Skilled Nursing Facility Data Call

Eight companies currently underwriting nursing home policies.

Only 13 percent of CA nursing homes covered by admitted insurers.

Average premium per facility $11,553.

Aggregate loss ratio 313 percent for SNF liability insurance.

Follow up was conducted by the CDI to focus on SNFs. In 2000, eight groups or admitted insurers covered SNF liability insurance, insuring 185 facilities or 7,617 beds. The average premium per facility was $11,553, compared to the $9,794 reported for all long-term care facilities. The SNF carriers reported an **aggregate loss ratio** of 313 percent, indicating that over 3 times the amount collected in premiums was expended in claims payments. The average loss per claim was $54,391. For the 185 facilities, 123 claims had been filed during the year. This data only captures the insurance experience for 13 percent of the skilled nursing facilities in the state. The remaining 87 percent are either self-insured, securing liability coverage through arrangements, or insurance companies not licensed in California, or are uninsured.

Rate Increase Trends

Between April 1999 and September 2001, four admitted insurer groups have filed for base premium rate increases in their SNF LTC liability lines. The nature of the requested increases range from 36 percent to 127 percent. The highest rate increase granted by the CDI was approximately 70 percent. The resulting premiums ranged from $170 per bed to approximately $525 per bed. If an insurer does not receive the base rate increase for which it files, the insurer still has the latitude in its premium structure to tighten up its underwriting process, or to not write new or renewal policies.

In addition, two new filings of liability insurance occurred during the same timeframe, by insurers that were not previously offering these liability insurance products in the market. The most recent filing was in September 2001. Of the new market entries, base rates ranged from approximately $650 per bed to $825.

Trend Data From Admitted Insurer

DHS received firm data from one major admitted insurance company, *CNA*, in preparation of this report. *CNA*, one of the largest admitted insurers still providing SNF liability insurance, indicated liability claims experience in California is increasing. In response, *CNA* is increasing its premium rates for 2002 to 2003 by 50 percent to 100 percent. *CNA*'s analysis indicates that over the last three years, the California **claims severity** trend, or the size of the claim, has increased 20 percent. The same measure nationally reflects a 15 percent trend. The **claims frequency** trend, or the number of claims, resides at six percent in California. On a nationwide basis this trend represents four percent.

In setting its premiums for 2002-2003, the insurer evaluated underwriting reports of current accounts, studied account performance for adverse loss experience, as well as other factors including economic and market conditions that may affect premium pricing, and policy terms and conditions. For-profit long-term care facilities that had coverage issued on an occurrence basis in the past will be converted to claims-made policies upon renewal, thereby reducing the insurance company's exposure to risk.

Other Trend Measures

Trend Data from Medicaid (Medi-Cal) Cost Reports

In an effort to gain a more complete picture of the liability insurance experience, OSHPD undertook a study of administration expenses submitted by nursing home providers to estimate expense trends that could be attributable to insurance costs. OSHPD collects data on all SNF facilities from its combined, Medi-Cal cost reports and from OSHPD disclosure forms. These data are the same source used by the DHS Medical Care Services Program to calculate

Medi-Cal rates. The combined "administration" figure is the only data element collected from the facilities that would include the liability insurance figures.

OSHPD reviewed data from 81 facilities that had disclosure reports ending June 30, 2001 and later, which had been filed as of January 15, 2002. From this sample, a median increase of 23 percent was found between 2000 and 2001. This trend may be attributable to liability insurance increases, or upward or downward pressures from other non-identifiable administrative costs. This data may also include varying renewal periods for the insurance policies. With increases occurring, renewals reported earlier in the reporting year may differ from reports later in the reporting year. For these reasons, this information is of limited use.

For SNFs, as with other California businesses, liability insurance is not the only overhead expense that has recently experienced large increases. The price inflation generated by the energy crisis and cost pressures of worker's compensation increases are also affecting the fixed costs facing these facilities.

Affect on Cal-Mortgage Insured Projects

The Cal-Mortgage program requires liability insurance for the long-term care facilities, to which they provide mortgage insurance (unless the parties agree to other terms in writing). Cal-Mortgage is a division of OSHPD that provides credit enhancement for eligible health care facilities, allowing the borrower to secure financing at the State's credit rate. When Cal-Mortgage insures a capital loan, the borrowed funds are guaranteed by the "full faith and credit" of the State of California.

The Cal-Mortgage project managers have been gathering anecdotal stories regarding the challenges some of the facilities are having in maintaining liability insurance. One SNF received a cancellation notice on its policy and it is attempting to procure a new policy. One quote that the facility received would mean an increase in premium from $60,000 to $500,000. An alternative option was to pay $173,000 for a policy with a $100,000 deductible. For this option the facility would still need additional coverage, since it would only be insured for a $1 million claim or $2 million maximum. The public recognizes this facility as an exemplary provider and DHS survey reports affirm this image.

Another nursing home has had liability coverage from The St. Paul Companies, which is eliminating its medical liability coverage. St. Paul quoted a renewal rate, which would mean an increase from $50,000 in 2002, to $273,000 for 2003. The facility has reported that it does not have any prior claims. An alternative insurer quoted a premium rate at $1500 per bed or $640,000. A multilevel nursing home in San Diego noted the problem of compounding increases: 20 percent in 2001, 40 percent in 2002, and a projected 20 percent to 40 percent increase in 2003.

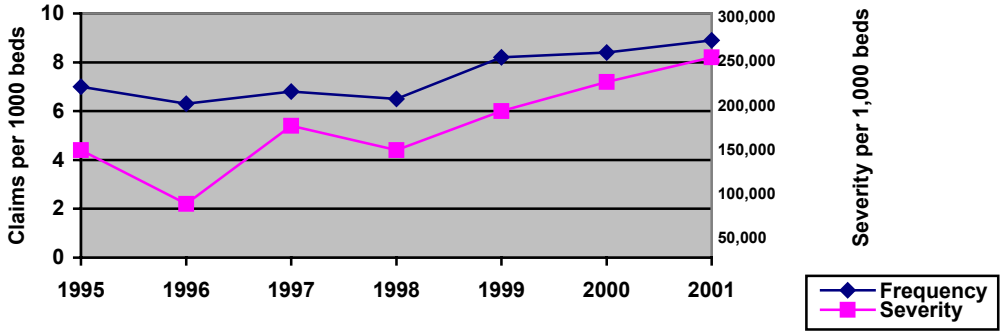
The Cal-Mortgage program is concerned about the burden that the liability rates will have on the facility operations. If an insured facility defaults on its mortgage, the State must take over the obligation.

Trend Data from America Health Care Association (AHCA)

The general trends for the frequency and severity of claims is reinforced by the finding of the Aon actuarial study of long-term care general liability and professional liability. Aon is one of the world's largest insurers, with services in the actuarial and consulting fields. Aon was commissioned by AHCA to evaluate liability rates for long-term care. The report was originally written to evaluate the conditions in Florida, but subsequent studies used California as a focus state and reviewed national trends. According to Aon's findings, the severity or size of the claims in California is trending upward at a higher rate than the frequency of the claims. The participants in this study represent approximately 27,000 occupied beds in California, or 22 percent of all California nursing home beds.[2]

FIGURE 2.

California Annual Number of Claims per 1,000 Occupied Beds /Severity per Claim



Theresa W. Bourdon, Sharon Dubin, "Long Term Care General Liability and Professional Liability Actuarial Analysis," Aon Risk Consultants, Inc. February 28, 2002, pg 28.

Historically, California has experienced higher frequency and severity levels than most other parts of the country.[3] Therefore, the trend line is flatter, yet the claims counts and severity levels are comparatively high.

General Discussions with Insurers

Claims-made vs Occurrence

General discussions with insurers have confirmed a shift to writing long-term care business on a claims-made rather than occurrence basis. "[I]nsurers that stay in the market are moving to a new system that covers the calendar year only—that

is, only claims filed during the calendar year that arose from events that occurred during the same calendar year. Nursing homes have to pay extra for past and future claims—called **"tail" coverage** in the industry—to get full coverage."[4] Traditional insurers start to restrict the occurrence-based policies issued as the environment they are insuring for becomes more volatile or starts to experience a higher number of claims than the insurer had predicted. This change results in a "**shorter tail**" or limits the insurance liability based on the date of claims. Currently, a large number of SNF claims have a **"long tail,"** where claims are being filed two or three years, sometimes more, after the incident took place. With a claims-made block of business, typically an insurer can respond more quickly to a changing risk environment and limit their exposure to legislative changes and to a rapidly changing legal environment. Under the CDI survey, however, the carriers reported that seven of the eight admitted insurers did write business on an occurrence basis in 2001 and did not require a minimum deductible. Updated data are not available for 2002 to demonstrate if this shift in policy form is truly a general trend that can be statistically validated.

Changes in Structure of the Insurance Policy

Other changes insurers reported in the structure of the policies they are now writing include additional deductibles, reduced maximum claims caps, and tightened underwriting criteria. Insurers are also restructuring current policies to eliminate coverage on punitive damages. All of these changes essentially increase the "cost" of liability insurance for nursing homes.

Impact of Lawsuits

"When multiple and/or large claim settlements are made and less than equal premiums collected, negative loss ratios become a focus for an insurance company. An insurer will then ultimately increase premium or elect to dismiss the book of business altogether which will entail canceling or non renewing the existing long term care insureds."

–Mealey's Nursing Home Litigation Conference 2002.

From an insurance perspective, the increased number of lawsuits is problematic, but of greater concern is the escalation of awards associated with the lawsuits and the insurer's inability to predict the settlements or contain the amount of the claims. "It may be easy to dismiss the large and highly publicized awards as aberrations that were later reversed or reduced, as many are. However, many claims are quietly settled in the still-lofty $1 million to $5 million dollar range."[5] The volatility in the market has resulted in the withdrawal of the insurers. Often, the insurers will press for settlement of the lawsuit with the specific intent of containing the claim cost, rather than risking what the jury may award the plaintiff for damages.

The insurers generally agree that the transition in insurance risk has occurred with the passage of elder abuse laws. *CNA* specifically noted that state statutes intended to clarify the rights of long-term care facility residents (the Elder Abuse and Dependent Adult Civil Protection Act, and the Patients' Bill of Rights) and their application in a litigious environment had resulted in escalating defense expenses, settlement awards, and jury verdicts.

GeneralCologne Re conducted a study of 58 voluntarily reported verdicts and settlements for LTC providers and concluded:

> Claim costs are escalating, multimillion dollar verdicts and settlements have replaced the more moderate payments previously associated with personal injuries awards to individuals with a short life expectancy and minimal wage loss. We found at least ten verdicts in excess of $10 million—four were over $50 million—and a long list of settlements at the $1 million mark.[6]

While insurers are unsure how to price a SNF liability product to appropriately ensure the companies' **underwriting profit**, they will either withdraw from the product lines, or limit the coverage, to mitigate the company's exposure to potential losses. The insurance companies have expanded their underwriting process to evaluate the condition of the facilities and the presence of any identifiable risks. *CNA* requests information regarding the structure and focus of the facility's risk management program, if one is in place.

One of the shifts towards limiting risk that the insurance industry is looking for are regulations to tighten the definitions of elder abuse. However, discussions with numerous insurers have also pointed to concerns regarding quality of care in the SNF, especially staffing, as a deterrent to insuring the facilities.

View of Risk for Long-Term Care Provider Types

Hospitals

Insurers view hospitals differently in assessing risk exposure. Some insurers have eliminated their coverage of freestanding SNFs, but continue to cover hospital-based SNFs as a portion of the hospital's overall liability policy, thereby diversifying the risk. Based on an interview with Zurich, a major insurer, which discontinued its coverage of freestanding SNFs three years ago, hospital staff tends to have a higher level of training and hospitals have tended to do better in trial, with fewer and smaller awards. Hospitals typically obtain liability insurance that covers all of their facilities, including the distinct part nursing facility. According to the California Healthcare Association, those who purchase commercial liability insurance are facing renewal premium increases in the range of 30 percent to 50 percent.

Not-for-Profit Facilities

Not-for-profit facilities have tended to have fewer lawsuits, but are also facing increases in premiums. There are some insurers that will write insurance for not-for-profit SNFs only. *CNA* indicated that they would still consider occurrence-based policies for these facilities, but not for-profit facilities. A study conducted by the American Seniors Housing Association indicates that a greater number of non-profit facilities have insurance coverage for punitive damages.[7]

For-Profit Facilities

For-profit facilities have had the poorest claims experience and this trend has led some insurers to differentiate their policies between the for-profit and not-for-profit status of nursing homes. In California, this differentiation is highly significant since over 80 percent of the state's nursing homes are for-profit.

Assisted Living Facilities

Assisted living facilities have also been affected. Insurance companies have begun increasing rates for these facilities, under the belief that similar risk factors exist for assisted living activities as for SNFs. Even though a single facility may not have ever experienced a claim, the insurance company will "pool" the category of coverage, based on location and the type of facility. An actuary will produce analytical projections to measure the risk and weight the exposure of the insurance company to potential claims. These projections can render industrywide increases, without the actual occurrence of increasing claims.

ICF-DD

ICF-DD facilities will assist patients with a higher need for care or for a more specialized type of care than assisted living or residential care facilities. These facilities have recently reported that they are experiencing an increase in their liability premiums.

STATE OF THE LIABILITY INSURANCE MARKET

The proponents for Lloyd's maintain that "the strength of the market comes from shedding the herd nature of the insurance industry."
- HSBC, "Lloyd's Destroying the Myths," January 28, 2000.

What Has Changed Nationally?

Insurance companies in many ways are the purest form of a market-based industry. Losses must be offset by profits. The nature of the insurance industry is to gain predictability and consistency by pooling resources and diversifying risk. Many insurance companies are huge multinational corporations with complex corporate structures, including multiple subsidiary companies, offering specialty lines of insurance or financial products. Historically, nursing homes represented low risk and a good insurance risk. Claims were moderate, but there were limited economic losses.

Perception of LTC Risk

A number of factors within the last few years converged to shift the insurance industry perception of LTC from a "real estate" to a "medical" liability model:

- ***Rising liability losses/change in risk*** – severity and frequency of lawsuits has increased, including the size of jury awards and settlements. Often settlements are structured so an insurer agrees to pay a minimum or maximum amount irrespective of the jury verdict. If the verdict exceeds the maximum, the insurer pays the ceiling—often in the LTC arena, the jury is awarding higher than the settled upon cap. Insurance companies currently view nursing homes as a volatile and high-risk market and therefore, the reinsurers are shying away from the coverage, or are setting their premium rates accordingly.

- ***Increased attention from the media/negative perception of LTC providers*** – numerous features on the LTC industry, largely focusing on occurrences of abuse and neglect, intensifying the public's opinion against the nursing home industry as a whole.

- ***Underpriced premiums*** – The insurers have miscalculated the price of the liability insurance. And during a competitive market period, underpriced premiums allow insurers to compete for market share and allow for additional revenues to be invested in the booming stock market. With the financial downturn in 2001, underpricing is detrimental to the stability of a line of insurance. Insurance companies must maintain a strong financial position to avoid downgrades by the rating agencies (see inset).

Who are the Rating agencies and why are they important?

Organizations competing in the insurance arena have become increasingly complex. Their corporate structures can span geographic borders and incorporate insurance and non-insurance industry segments. Independent ratings are the global standard for assessing the financial strength of insurance companies. Assessing an insurer's ability to honor its long-term commitments is important to distributors, consumers, and financial-market participants around the world. Rating agencies such as A.M. Best, Moody's, and Standard & Poor's provide an objective benchmark and credible financial data to evaluate an insurer's operations and competitive viability.

Rating agencies use a scorecard approach to assign a "grade" to denote the financial strength of an organization. Agencies will also denote an outlook rating to indicate the potential of any anticipated future changes in the rate assignment.

A rating agency defines an organization's success as its ability to respond to a dynamic market, as measured by strong capitalization and operating returns, and a market profile to ensure ongoing viability and financial security. "Insurers that possess a high degree of strategic and operations agility will inevitably return more value to stakeholders and be better positioned to leverage market opportunities."

A.M.Best Company "About Our Ratings."

- ***Record losses for reinsurers –*** Prior to the September 11th terrorist attacks, insurance carriers were experiencing poor underwriting results. The reinsurers—the insurers of the insurance companies—were absorbing the losses that the insurers were experiencing due to the underpricing of the property coverage issued. The reinsurers have dramatically increased premiums to the carriers to cover these losses.

- ***Diminishing equity returns*** – The change in the stock market performance has eliminated a significant subsidy for the insurance market. Therefore insurance companies have more closely reviewed the underwriting performance of the various segments of their portfolio and corrected for shortcomings by premium increases. These pricing corrections have affected automobile insurance, homeowners insurance, and all sectors of liability and medical malpractice insurance.

- ***Events of September 11***– The overall impact of September 11th is still being assessed. It will be noted as the single costliest event in insurance history. The events of September 11 will serve to only speed the **"hardening"** of the market that was already underway. While the losses incurred are being assessed, many reinsurers are freezing their current blocks of business, not writing new business, or in some cases canceling their policies and renegotiating any business they take back. The reinsurers must raise their prices to stay in business.

Cyclical Nature of Insurance

As the industry hardens, insurance companies return to their core businesses and eliminate lines that are volatile or experiencing uncontrolled losses.

The insurance industry, like other industries, is cyclical in nature. While the insurance industry has enjoyed a **"soft"** or expanding market in the past decade, conditions have changed and the market is now hardening, or contracting, as a response to a variety of factors affecting the national insurance industry as a whole, and long-term liability insurance more specifically. The insurance companies are restructuring to minimize losses that have resulted from a myriad of industry factors, few of which have any direct correlation to the nursing home industry. As the industry hardens, insurance companies return to their core businesses and eliminate lines that are volatile or experiencing uncontrolled losses. Currently, insurance companies are shedding lines of medical liability insurance—these are considered to be volatile. These insurance companies will re-adapt to the market conditions and re-position for new opportunities that arise.

As an example, The St. Paul Companies, the largest US underwriter of medical liability and product liability coverage, is exiting the malpractice market. The St. Paul has seen and survived the up and down cycles of the

insurance industry many times over. The company was founded in 1853 and operates worldwide.[8] At the end of 2001,The St. Paul Companies released plans for restructuring to focus on core business lines, shore up reported loses, and reverse the negative outlook of the rating agencies. At the forefront of the restructuring is the exit of the medical malpractice business on a global basis through non-renewal upon policy expiration.[9] In response to the announced changes, A.M. Best affirmed the A+ (Superior) financial strength rating of The St. Paul Companies, Inc. This decision was based on the rating agency's review of the group's initiatives to build a leaner, more focused company.[10]

Even beyond nursing homes, placing liability coverage has been plagued by the up and down cycles of the insurance market. In 1986, Congress passed the Liability Risk Retention Act to help U.S. businesses, professionals, and municipalities obtain liability insurance that had become either unaffordable or unavailable due to the "liability crisis" in the United States. The Liability Risk Retention Act was a marketplace solution, enabling insurance buyers to have greater control of their liability insurance programs. Two entities were created under this federal act, **risk retention groups** and **purchasing groups**. These market options can be utilized by associations or brokers to facilitate additional, customized, insurance products (see Table 3, page 24).

Implications

The market changes affecting the insurance industry are hard to predict and even more difficult to influence. However, the industry is reacting to identified problems in the LTC arena. Concerns about quality of care in the SNFs have caught the attention of the media, with feature stories being run depicting conditions in the nation's SNFs. Congress continues to monitor for improvement in facilities and has taken action to enable states to adopt more stringent elder abuse laws. Within California, the elder abuse laws were intended to encourage lawyers to represent the families of abused or neglected adults. (Welfare and Institutions Code, Section 15600 [j]).

It is difficult for regulators to assess the level of risk facing the nursing home residents because of problems being experienced by facilities in securing reasonable liability insurance coverage. There is no reporting requirement or other mandate that will serve to inform DHS as to the level or existence of liability insurance or as to the status of litigation facing the facilities.

The end goal is to improve the quality of care for seniors and dependent adults. Fear that insufficient care is being provided in nursing homes is the root of increasing insurance rates nationwide. However, the insurance industry response—increased liability insurance rates—is troublesome to both exemplary and poor performing facilities. In crafting a solution, a review of the insurance rates, underlying quality of care, and the legal environment are important in a balanced approach to reform.

Lloyd's of London
A unique insurance market

Lloyd's of London provides a major market resource for liability insurance and reinsurance. Lloyd's has a unique operation and is labeled as specializing in high-risk exchanges. More accurate is that Lloyd's provides specialized insurance coverage and serves as a venue for many surplus and excess line transactions. This article serves to clear up some of the Lloyd's mystique.

The famous Lloyd's of London, considered the birthplace of the insurance market, acts as a barometer to meter the state of the insurance industry. The fact that Lloyd's has registered a loss five out of the last nine years is further evidence of the current challenges facing the insurance industry, and the hardening of the market.

The origins of Lloyd's can be traced back to 1688 and Edward Lloyd's Thames-side coffee shop. Wealthy individuals who frequented the coffeehouse would take shares in policies offered to them in return for a share of the premium. Signing their names one below the other on the policy documents, the participants soon became known as underwriters.

Lloyd's of London is not an insurance company. It is a market, providing a venue of exchange for Underwriting Agencies or Syndicates who compete and co-operate. Lloyd's oversees and regulates the competition. Each Managing Agent of a Syndicate will underwrite business from the brokers and find financial backing to insure the risk. Lloyd's focuses on high-risk, specialty insurance for businesses.

Lloyd's has developed a unique mode of operation—much of which has faced criticism in light of the poor market performance of late. The accounting system for the Lloyd's accounts run on a three-year cycle, as opposed to the standard single year GAAP (Generally Accepted Accounting Principles) accounting standard. Also, Syndicates renew all financing ventures annually, without the long-term ties typical of the insurance industry. There is also a system of unlimited-liability, which exists only on the Lloyd's market, backed not by corporations, but by individuals often known as "Names." The Lloyd Syndicates are minimally invested and Names do not book these results on their operations for the Lloyd's market.

Lloyd's maintains adequate, but lean capitalization—this may not produce the same standard in rating that other, "over" capitalized insurers maintain.[Φ] (Rating agencies favor higher capitalization as a perceived security for the business.) However, A. M. Best still gives the overall Lloyd's market an A (Excellent) rating. Lloyd's underwriting returns are more volatile and tend to lead in and out of cycles more quickly than the insurance market as a whole.

The Lloyd's market can also be accessed for reinsurance, which comprises more than half of Lloyd's total business.

All of these factors have cast a shadow over Lloyd's of London as a highly speculative market arena with only the insider truly being able to decode the state of affairs. The proponents for Lloyd's maintain that the strength of the market comes from shedding the herd nature of the insurance industry and providing a focus on a single underwritten account; allowing for an innovation and entrepreneurship unequalled in the insurance market.

[Φ] HSBC, "Lloyd's, Destroying the Myths," January 28, 2000.

[1] Fine, op. cit., p. 8.
[2] Theresa W. Bourdon, Sharon Dubin, "Long Term Care General Liability and Professional Liability Actuarial Analysis," Aon Risk Consultants, Inc., February 28, 2002, p. 27.
[3] Ibid.
[4] "Without a Net," *Sacramento Business Journal,* February 1, 2002, p. 19.
[5] Allison Schmitz, "Current state of the U.S. Long-Term Care (LTC) market," *Topics,* GeneralCologne RE, 9, p 32.
[6] Ibid. p. 35.
[7] American Seniors Housing Association, "Seniors Housing Liability Report," quoted in "Manage Risks or Kiss Coverage Goodbye," *Eli's Senior Housing Report*, Volume V 2001, p. 166.
[8] The St. Paul, "Fact Sheet," www.stpaul.com/wwwcorporate.
[9] The St. Paul, "The St. Paul announces fourth-quarter actions to improve profitability and business positioning," www.stpaul.com/wwwcorporate.
[10] The St. Paul, "A.M. Best Affirms St. Paul's Financial Strength Rating and Lowers Debt Ratings," www.stpaul.com/wwwcorporate.

TABLE 3.

INSURANCE OPTIONS

	Who Regulates	Who is covered	Financial Obligation	Type of facility
Risk Retention Group (RRG)	Federal law (Title 15, Chapter 65, Sec. 3901). Regulated by the charter state	Once licensed by its state of domicile, an RRG can insure members in all states, as long as the members of an RRG are engaged in business or activities that are similar in regard to the liability exposures created.	This entity operates as an insurance company and therefore retains the risk of the product line and requires the capitalization to establish reserves. RRGs may also be formed to provide reinsurance.	Once the insurance entity is formed, companies of all sizes can be insured. Can be created by a trade organization or professional groups.
Purchasing Group (PG)	Federal law (Title 15, Chapter 65, Sec. 3901). Insurance carriers are regulated by domicile state. May include insurance companies operating on an admitted basis, a surplus lines basis or a risk retention group.	A PG is an insurance purchasing vehicle. The members of the group must have similar liability exposure and the PG can provide customized coverage designed for the members, including risk management programs and credits for low loss experience.	Since the PG is not an insurance entity it does not require capitalization.	Companies of all sizes can be insured. Can be created by a trade organization or professional groups.
Joint Underwriting	California Department of Insurance (CDI) (Insurance Code Section 1853.9 & 1856)	An organization can be formed to allow for joint underwriting or joint reinsurance under the California Insurance Code. CDI requires an organization to file a copy of its constitution; its articles of incorporation, agreement or association; and its by-laws, rules, and governing regulations.	The entity operates as an insurance company and therefore retains the risk of the product line and requires the capitalization to establish reserves.	The incorporated entity.
Specialized Insurance pool	California Department of Corporations Not subject to regulation under the Insurance Code. (Corporations Code Section 5005.1).	California regulations have provisions for insurance pools to be established for two or more health care organizations.	Initial pooled resources of $250,000 are required to establish an insurance pool. Premium payments or other mandatory financial contributions are required of the members to ensure a financially sound risk.	Two or more organizations that are structured to provide or fund health or human services. (Hospitals are not included).

INSURANCE OPTIONS

	Who Regulates	Who is covered	Financial Obligation	Type of facility
Captive Insurance Company	State Department of Insurance In some states, state laws do not allow captive insurance programs to issue insurance policies. In these instances a captive insurance company uses an admitted insurer to front the insurance program.	Most captives act as risk financing vehicles for corporations where the conventional insurance market is unable to provide flexible, stable, and financially attractive terms. A captive insurance company is formed to provide: direct access to the reinsurance markets, coverage tailored to specific needs, accumulation of investment income to help reduce net loss costs, controlled cashflow, incentive for loss control, underwriting and **retention** funding flexibility. Claims may be handled through a third-party administrator or internally, providing the insured greater control of the claims.	This approach is a form of risk financing through which a firm assumes all or a part of its own losses.	A single-owned or pure captive is set up only to handle the risk of a parent company. Group captives are owned by multiple entities. An association captive insurer is owned by members of a sponsoring organization or group, such as a trade association (can be an RRG).
Self-Insured	Self-insurance regulations are promulgated by each of the states and differ from state to state.	Large organizations can reap several benefits from self-insuring. The corporation has the flexibility to raise or lower its retention amount depending on the market pricing for excess insurance. Directly retaining losses increases the internal sensitivity to loss results, and offers the corporation greater control over the claims management process. However, these benefits can quickly disappear if the organization does not have a plan for paying losses when they occur.	A qualified self-insured is usually required to securitize the loss reserves through cash, letters of credit, and/or bonds. The fund auditors will require reserves to be established based on industry rated exposure. The funds that are reserved for potential insurance claims are taken off-balance sheet and show an impact on the company's bottom-line.	Large Corporations, Chains/Systems

INSURANCE OPTIONS

	Who Regulates	Who is covered	Financial Obligation	Type of facility
Self-funding a large deductible	An insured with a deductible program does not have to formalize their self-insurance program with the state.	Under this arrangement, the provider (facility or corporation) secures an insurance policy that has a very large deductible. This allows the provider to self-fund losses up to a certain threshold, after which it has an insurance policy that would take effect.	The insurance carrier will typically require some securitization of the loss reserves.	A single facility or corporation.

III. QUALITY OF CARE OVERSIGHT AND REIMBURSEMENT

Ensuring quality of care in nursing homes has always been an objective of responsible government agencies. The federal and state oversight and funding systems for nursing homes are extremely complex, but beyond continued stringent enforcement, the gradual change of focus emerging for these systems is one that:

- *supports facility risk management, quality improvement, and compliance programs as methods to achieve quality improvement;*
- *expands the amount of historical facility performance data and quality indicator information available to allow informed choice for consumers;*
- *emphasizes the critical importance of adequate staffing to achieve quality improvement;*
- *acknowledges caregivers that provide exemplary care; and*
- *considers quality indicators and positive outcome data in the methodology for paying nursing homes to encourage quality improvement.*

> "The structures, incentives, and forces at work in the U.S. health system produce exactly what we should expect in the quality of care for chronic disease: highly variable patterns of care, widespread failure to implement recognized best practices and standards of care and the persistent inability of provider systems to achieve substantive changes in patterns of practice."
>
> – Molly Coye, Chief Executive Officer of the Health Technology Center in "No Toyotas in Health Care," *Health Affairs (Nov/Dec 2001).*

The perception of whether quality care is being provided in nursing homes, can directly affect the cost and availability of liability insurance. Experts, however, struggle to define quality of care in concrete terms. The purpose of nursing homes, described in federal law, hints at the complexity involved: " A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, of each resident." [1]

Insurers, evaluating the effectiveness of current oversight and reimbursement actions, see a greater degree of risk in today's market for writing liability

*insurance. Increased numbers of claims from **civil actions** indicate that consumer expectations regarding quality of care are not being met.*

*Nationwide and in California, dissatisfaction with the quality of care provided in nursing homes appears significant. Elder care abuse cases are in the headlines. Federal and state oversight activities are criticized as inadequate. Since 1997 the General Accounting Office (GAO), the investigative arm of Congress, has published dozens of reports related to quality and reimbursement issues for nursing homes. Governor Davis began developing his **Aging with Dignity Initiative** soon after taking office because of his desire to ensure that elderly and disabled Californians have high quality LTC options available.*

REGULATION AND OVERSIGHT OF NURSING HOMES

Nursing homes can be either freestanding SNFs, meaning that they are not a part of any other health care facility, or hospital based, meaning they are a distinct part within a general acute care hospital (DP/SNF). They can be for-profit facilities, meaning that they are investor-owned, not-for-profit, or operated by the government. California has 1440 licensed nursing homes with 130,821 available beds. Nursing homes provided 38,271,700 patient days of care in 2001 (see Table 4, page 41, for detail). Over 80 percent of the nursing homes in California are for-profit, freestanding facilities.

Nursing homes are one of the most regulated of health care providers. A DHS team of trained health professionals conducts an intensive **survey** of each California nursing home at least once every 9 to 15 months. The inspections average over 150 hours and include not only examination of administration and physical plant, but also an assessment of the quality and adequacy of care. The survey team members review quality indicators based on patient assessment data, and observe, interview, and review medical records to determine compliance with federal and state requirements. Surveyors conduct onsite visits to investigate all **complaints** against nursing facilities. If the complaint indicates there may be an immediate and serious risk to a resident, the investigation will take place within 24 hours of the call.

Certified nurse assistants (CNA), provide 60-80 percent of the care in nursing homes. While **Registered Nurses (RNs)** and **Licensed Vocational Nurses (LVNs)** are responsible for the remaining direct care services. CNAs must be certified by DHS before they can provide care in a SNF. To become a CNA, an applicant must pass a physical exam, submit fingerprints prior to resident

contact, and pass a background check that indicates no criminal convictions for Penal Code provisions specified in law. The applicant also must complete a minimum of 160 hours of training in a DHS- approved program and successfully complete a competency exam conducted by a DHS-approved testing vendor.

Vulnerable Residents
It is easy to understand why so much time and energy is focused on this segment of healthcare in the United States. The residents of nursing homes are typically over 75 years of age, very ill, very frail, and often disoriented. They are in a nursing home for the purpose of continuous access to skilled care.

Despite regulation, a February 2002, national survey by *The NewsHour with Jim Lehrer,* the Kaiser Family Foundation, and the Harvard School of Public Health found that nursing homes are not seen as a particularly positive care choice:

> Majorities of the public believe that nursing homes are understaffed…, that nursing home staff are often poorly trained, that at least some nursing home residents are abused and neglected, that many residents do not have enough privacy…and that many residents are lonely.[2]

Aging with Dignity

- ✓ **Care Options**
- ✓ **Tools to Choose**
- ✓ **Qualified Care Givers**
- ✓ **Provider Incentives**
- ✓ **Effective Oversight**
- ✓ **Financial Stability**
- ✓ **Quality of Care**

State Strategy to Improve Care for the Aging
Upon taking office in 1999, Governor Davis quickly ascertained that improvements were necessary to the system of long-term care for Californians. He based his comprehensive "Aging with Dignity Initiative" on the principles that:

- Consumers need options for meeting their health care needs and the tools to make wise choices among their options;
- Caregivers need to meet appropriate qualifications and be given support and incentives to excel; and,
- Government needs to maintain an effective and responsive regulatory framework to ensure the quality of services.

Another major focus of the Governor's approach to nursing homes within the Initiative was his recognition of the direct relationship between quality of care and the financial stability of the facility where care is being provided.

The Administration strategy utilizes statutory changes, budgetary provisions, and administrative actions and includes components to help seniors stay at home,

increase the availability of community based alternatives to nursing homes, and enhance the quality of care in nursing homes. Current State activities to improve quality oversight in nursing homes and to modify the Medi-Cal rate methodology, are examples that highlight the policy focus for nursing homes within the Aging with Dignity Initiative.

Federal Medicare and Medicaid (Medi-Cal) Programs

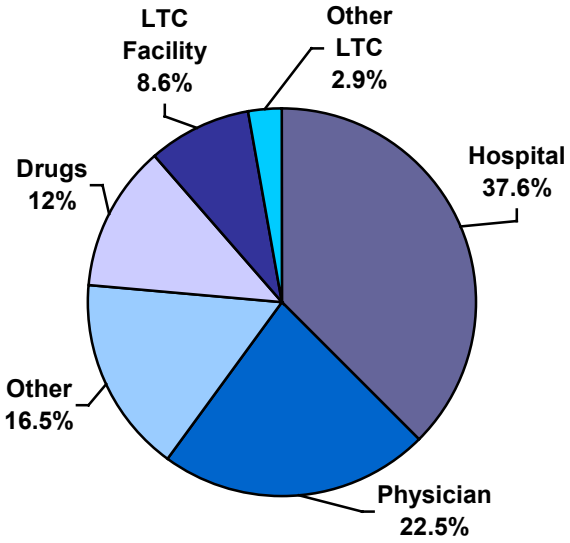
Nursing home costs represent almost nine percent of U.S. personal health spending. Forty-six percent is paid by Medicaid and 11.8 percent by Medicare.[3] In California, the total estimated Medi-Cal expenditures for fiscal year 2002-03 for SNFs and ICF/DD facilities is $3,104,038,000. This represents approximately 12 percent of all Medi-Cal expenditures. Over two-thirds of California nursing home payments are from public funding sources.

OVERALL SPENDING

Out of all U.S. personal health spending, $117 billion was spent on long-term care services in 1998. Spending for nursing homes and intermediate care facilities for the mentally retarded (ICF/MR) represented 75 percent of all long-term care spending.

FIGURE 3.

Personal Health Spending in the U.S. 1998



Source: *Urban Institute, 2001*. Based on Office of the Actuary, National Health Statistics Group, Personal Health Care Expenditures, HCFA, DHHS, 2000.

Since the majority of SNF payments are made by government entities, Medicare and Medicaid become the driving forces for change in how care is provided to nursing home residents. Federal efforts to improve the two programs have focused on strengthened oversight, residents' rights, increases in staffing, and improved quality of care.

Medicare is the federal health insurance program for individuals age 65 and over, and for specified individuals with disabilities. The program covers nursing home services for beneficiaries discharged after a qualifying hospital stay, for up to 100 days. Once beneficiaries' coverage lapses, if they have assets, they would **self-pay**. If they do not have assets, or if they "spend-down" their assets, they become **Medicaid (Medi-Cal** in California**)** eligible.

DHS contracts with the CMS to conduct nursing home surveys that monitor quality of care and enforce compliance with federal requirements. DHS also **licenses** all nursing homes in California and is responsible for ensuring that all residents are safely transferred if a facility is to be closed. Only 25 nursing homes in the state are "licensed only," meaning they serve private-pay residents only. All other SNFs are **certified** to receive Medicare or Medi-Cal reimbursement, or both. Virtually all facilities in this State are therefore required to meet the quality compliance standards set by the government financing programs.

CHANGES IN THE FOCUS OF QUALITY OVERSIGHT

Measurement and Comparison of Quality Indicators and Outcomes
Almost 15 years ago, the federal government established a framework to ensure the provision of high quality services to nursing home residents whose care is paid for by Medicare and Medicaid. In the '70s and '80s, serious abuses had been identified nationwide in the treatment of some nursing home residents. The **Omnibus Budget Reconciliation Act of 1987 (OBRA '87)** contained major changes to federal methods of oversight to address these issues.

The revised monitoring approach established in OBRA '87 was intended to be outcome-based, seeking to measure positive or negative results of the care provided. It focused on whether a facility was appropriately assessing its residents, planning a course of action to meet their multiple needs, and taking actions that were responsive to residents' wishes, capabilities, and changing status.

Providing care to residents of LTC facilities is complex and challenging work. It utilizes clinical competence, observation skills, and assessment expertise from all disciplines to develop individualized care plans for residents. The **Resident Assessment Instrument (RAI)** was developed by the federal government to help facility staff to gather definitive information to be addressed in an individualized care plan.

Since OBRA 87, the federal framework has continued to evolve towards a data driven system that can use quality and compliance data to target poor performing facilities for further review. The availability of more accurate automated data also

allows Medicare and Medicaid reimbursement systems to utilize prospective rates that consider requirements and needs of the resident in determining payment. Table 5 (see page 46) summarizes some of the basic policy and reimbursement changes that have helped define the current Medicare and Medicaid focus.

CMS Quality Demonstration Project

CMS has taken significant steps to emphasize quality of care, outcome measurement, and empowerment of consumers through provision of detailed information from which to evaluate SNF care. In January 2002, CMS began a five-state demonstration to identify, collect, and publish nursing home quality information in Colorado, Maryland, Ohio, Rhode Island, and Washington. The quality measures identified would be recognized and accepted by consumers, clinicians, and healthcare providers. CMS began publishing the information on April 17, 2002, to help make people aware of how performance differs across nursing homes. Following the pilot project, CMS will refine and expand the initiative to include risk-adjusted quality information from nursing homes in every state. The national project is scheduled to begin in November 2002.

The Quality Indicators (QIs) include percentage of:

- Residents Who Need More Help Doing Daily Activities
- Residents with Pressure (Bed) Sores
- Residents Who Lost Too Much Weight *(removed in the final version)*
- Residents with Pain
- Residents with Infections
- Residents in Physical Restraints
- Short-Stay Residents Who Improved in Walking
- Short-Stay Residents with Pain
- Short-Stay Residents with Delirium [4]

Financial Stability and Quality Incentives

In California, Governor Davis began implementing his Aging with Dignity Initiative in 2000. The nursing home reform legislative component, AB 1731 (Chapter 452, Statutes of 2000) emphasized improved information for consumers, substantial resources to support direct caregivers, recognition of exemplary facilities, and tougher enforcement provisions. The legislation also introduced provisions to focus on the direct relationship between quality of care and the financial stability of the facility where care is being provided (see Table 5, page 46).

Financial Stability

Since 1998, facilities have been required to notify DHS in writing within 24 hours of filing a bankruptcy petition. In order to protect residents during any transfer that might occur due to bankruptcy, when the bankruptcy court appoints a trustee, DHS must notify the trustee of the requirements for operating a licensed LTC facility.

AB 1731 provisions went substantially beyond the requirement for notification of bankruptcy filing. Facilities now are required to report to DHS whenever early symptoms of financial distress occur. When a facility submits a licensing application, renewal, or **change of ownership (CHOW)** request, DHS places greater scrutiny on the companies that manage nursing homes as well as the licensee organization. DHS also established a **SNF Financial Solvency Advisory Board**. The Board consists of a panel of experts to advise DHS of appropriate financial standards for facilities and methods to monitor facility financial status.

Quality Incentives

AB 1731 also included a **Quality Awards Program** to encourage and acknowledge efforts to provide the highest quality of care. Provisions require awards to SNFs with performance histories that indicate they provide exemplary care to residents. Funding was also made available for an **Innovative Grants Program** to encourage projects that demonstrate methods to improve quality of care and quality of life for residents.

CARE GIVERS AND QUALITY

Aging with Dignity Focus on Nursing Home Staffing

Both federal and state regulatory authorities recognize the importance of adequate staffing to ensure quality of care in SNFs. California now has one of the highest direct care staff standards. One of the major principles guiding the Governor's Aging with Dignity Initiative is its emphasis on the caregivers, both ensuring that they have adequate qualifications and that they have adequate incentives to provide care. Staffing costs account for 54 percent of total freestanding SNF costs, and CNAs provide the majority of direct care in nursing homes.

Governor Davis included provisions in Assembly Bill 1107 (Chapter 146, Statutes of 1999) that increased California's minimum nursing staff requirement to 3.2 hours of direct patient care per day effective January 2000. This gave California the third highest standard in the country at that time. The change was in direct response to concerns about the effect that relatively low levels of direct patient care staff in nursing homes had on quality of care.

AB 1731, the Governor's nursing home reform bill, continued this focus on direct care staffing. The bill required DHS to submit a report to the Legislature by May 2001 that addressed the adequacy of the new 3.2 hours per patient day standard to ensure quality of care. While the report recognized the importance of adequate staffing to ensure quality of care, it concluded that sufficient empirical data were not available to recommend an increase to the minimum staffing requirement.

In the legislative report, DHS instead recommended the development of a rate-setting system that reflects the costs and staffing levels associated with quality of care for nursing home residents. It also recommended future consideration of converting the minimum staffing requirement from the current hours per patient day standard to a staff to patient ratio standard. This change would allow residents and their families, facility employees, and state inspectors to determine easily whether or not a facility is in compliance. Assembly Bill 1075 (Chapter 684, Statutes of 2001), included language to implement these recommendations from the May 2001 report (see Table 5, page 46).

Federal Staffing Research

> "…for virtually all types of nursing staff, there is some ratio of staff to residents below which residents are at substantial risk of increased quality problems."
>
> *—Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes (Phase I) 9-16.*

In July 2000, the federal Health Care Financing Administration (HCFA, now CMS) published a *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes (Phase I).* The Phase One study findings indicated that it is possible to identify significant staffing thresholds. The first threshold, HCFA's "Minimum Staffing Level," is the threshold below, which care of residents is likely to be compromised.

The federal Department of Health and Human Services (DHHS, HCFA/CMS' parent Agency) issued the Phase II Report in March 2002, but was unwilling to establish mandated staffing requirements based on either the Phase I or Phase II report findings. In a letter accompanying the Report, submitted to Congress, DHHS indicated that:

> "The question of the relationship between the number of staff and quality of care is complex and the Phase I and Phase II studies made good faith efforts at addressing the question. However, the Department has concluded that these studies are insufficient for determining the appropriateness of staffing ratios in a number of respects. Specifically, we have serious reservations about the reliability of staffing data at the nursing home level and with the feasibility of establishing staff ratios to improve quality given the variety of quality measures used and the perpetual shifting of such measures."[5]

Consumer advocates point to the study, however, as validation that "nursing homes have too few workers to care properly for residents, putting them at significant risk for such health problems as bedsores, blood borne infections, dehydration, malnutrition and pneumonia." [6]

Direct Care Staffing is a Consideration for Liability Insurers

Staffing also is found at the top of the list when insurers evaluate which facilities appear to be "good risks." The Texas Department of Insurance (TDI) has created a tier-rating system of nursing homes that considers a number of factors that determine risk of insurability. The rating system, however, only applies to nursing homes applying for admission to the state's **Joint Underwriting Association (JUA)**. At this time only one nursing home has obtained coverage under the JUA. The system is an important start in developing a public rating system of the nursing home industry. It includes:

- Past Claims Experience;
- Quality of Care Rating (An Online State Rating System);
- Staff Ratios;
- Tenure and Credentials of Key Personnel;
- Risk Management, Loss Control, and General Safety; and
- Ombudsman Program Evaluation.[7]

CHANGES IN NURSING HOME REIMBURSEMENT FOCUS

Government, through administration of the Medicare and Medicaid Programs, is the major provider of funding for nursing home care in the United States. For this reason, it retains oversight responsibility and sets the parameters for services provided with those funds.

A shift in focus is occurring at the federal and state level, to utilize quality indicators and positive outcome data from its system of oversight, in reimbursement methodologies structured to encourage quality improvement. The **Office of the Inspector General (OIG)**, the federal organization with primary authority for protecting the Medicare program and its beneficiaries, has also instituted several programs that rely on collaboration, cooperation, and voluntary compliance on the part of the health care industry to fight health care fraud and abuse.

Medicare

Medicare payments are currently based on a Prospective Payment System (PPS) that establishes a per diem payment for each Medicare resident, adjusted to reflect differences in resident characteristics and service needs. The changes in the method of payment were part of the Balanced Budget Act of 1997 (see Table 5, page 46). Federal testimony, presented before the Senate Special Committee on Aging on September 5, 2000, asserted PPS was necessary to curb escalating health care costs.[8] The previous cost-based reimbursement method, combined with a lack of appropriate program oversight, had provided few checks on the growth in Medicare spending for SNF services.

Implementation of New Medi-Cal Reimbursement Methodology

Medicaid (or Medi-Cal in California) is the federal assistance program for low-income and other eligible individuals with healthcare needs, implemented in partnership with state governments. The state establishes an approved program, and the federal government will pay a percentage of the state's claims expenditures, or match the state Medicaid payments.

Medi-Cal currently uses facility cost data reported on the integrated long-term care disclosure and Medi-Cal cost report to derive a flat rate structure for paying nursing homes (see insert). AB 1075, requires that California adopt a facility-specific rate-setting system for nursing homes by 2004 (as well as the changes to minimum staff standards discussed earlier).

DHS has contracted with Tucker Alan, Inc., to devise a Medi-Cal LTC reimbursement methodology to encourage access to services, high quality resident care, appropriate wages and benefits for nursing home workers, provider compliance with requirements, and administrative efficiency.

CURRENT MEDI-CAL RATE DEVELOPMENT PROCESS

To develop rates DHS currently uses:
- ✓ facility cost data reported on the integrated long-term care disclosure; and
- ✓ Medi-Cal cost reports

DHS consults with provider associations and others to gain support of the assumptions used.

Rates are updated August 1 each year.

Each facility's rate is a prospective determinate of:
- ✓ direct patient care labor;
- ✓ capital-related assets; and
- ✓ other considered costs.

Reported costs are trended by a DHS-determined economic indicator factor.

Peer groupings are developed based on geographic factors and number of beds, as appropriate.

Tiers of payment are established based on median costs of the peer group.

Capital-related medians are limited by a ceiling at the 75th percentile and a floor at the 25th percentile.

In its review of quality of care issues, Tucker Alan intends to:
- Interview chief architects of the Medicare system of minimal data set (MDS) and quality indicators.
- Determine appropriate data sources for analyzing quality of care information in California facilities.
- Review quality of care incentives used by other state Medicaid agencies.
- Evaluate the on-going California project regarding quality of care, the web-based Consumer Information System.
- Identify potential quality of care indicators.

DHS is to report progress periodically to the Legislature on development of the rate-setting system.

Reimbursement Oversight

Multiple units within DHS are involved in oversight of nursing home payments. DHS Medical Care Services (MCS) and Electronic Data Systems (EDS), the fiscal intermediary contractor, monitor and administer the reimbursements to nursing homes. The Medi-Cal Rate Development Branch establishes rates, using data from the cost reports submitted by providers to OSHPD and the results of cost audits conducted by the Audits and Investigation (A&I) Division. In the past, L&C involvement in reimbursement oversight has been limited. The L&C focus is licensing of nursing homes, compliance with federal and state quality standards and enforcement actions against facilities.

Blending Reimbursement and Quality

AB 1075 requires a facility-specific rate setting system that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities. The workload associated with a facility-specific rate-setting process is significantly more complex than the current flat rate system. At a minimum, such a system may bring into consideration the case mix of nursing facility residents, including their clinical condition and resource needs.

In order to develop an appropriate system, L&C professional staff need to validate the accuracy of the resident assessment, **Minimum Data Set (MDS)**, data submitted by facilities, comparing them to actual medical records. In addition, since the incentive exists to "over-report" costs in a case mix system, an expanded A&I Division audit program and expanded data are needed.

Developing this new Medi-Cal reimbursement methodology, combined with increasing emphasis on quality indicators, outcome measurement, staffing and financial solvency of nursing homes, requires greater integration of oversight and reimbursement functions within DHS.

Liability Insurance and Medi-Cal Rates

The current Medi-Cal rate methodology provides for a rate adjustment to reflect changes in state or federal laws and regulations (and may recognize other extraordinary costs) that would affect the historical costs of the facilities, commonly referred to as an "add-on." During the 2000/2001 long-term care rate study; DHS recognized a rate add-on to certain LTC providers to reflect an acknowledgment of the increasing cost of liability insurance. The liability insurance "add-on" was approximately $1.09 per patient day.

DHS is analyzing industry requests (and supporting documentation) to increase rates in response to rising liability costs. Details regarding the methodology to be implemented in response to AB 1075 are not yet available, as the rate methodology study is in the preliminary stages. It is unknown at this point, how or whether liability insurance will be factored into this new rating formula.

Opinions differ as to the appropriateness of such a rate adjustment. Consumer advocates and providers disagree about the cause for problems with availability and cost of liability insurance. Liability insurance, by definition, covers a facility's legal liability that might result from injuries to residents or others. Consumer advocates and attorneys believe that increases in the frequency and amount of settlements and awards in lawsuits against nursing homes reflect poor care. In the words of one advocate, "insurance rates increase as risk increases among nursing homes that are not providing adequate quality of care."[9]

Providers believe that the prevalence of litigation is due to overly aggressive attorneys that actively solicit cases, encourage suits and inflate claims. Providers also do not see an "empirical relationship between facilities' experiences and the increased cost" of liability insurance.[10] Facilities providing a high level of care are being penalized along with those providing poor care.

In developing the Medi-Cal facility-specific rate methodology, the relationship between increased administrative costs for liability insurance, and the cost for provision of services will need to be carefully studied.

NEED FOR PRIVATE PAYMENT FUNDING SOURCE

Increasing liability insurance costs are particularly problematic for government payers. Reimbursement cannot be separated from the fiscal well being of a facility, and insolvency has major implications for the state agency, in terms of negative impact on residents and an unanticipated financial burden for taxpayers.

LTC Insurance Affect on Medicare and Medi-Cal

CMS noted in a recent financial report that nursing home per diem rates steadily decline as a resident's financial eligibility shifts from Medicare to private pay to Medicaid. The report also indicates that the Medicare rate of growth in spending has dropped significantly for nursing homes since the Balanced Budget Action of 1997."

The federal fiscal year (FY) 2003 budget includes an above-the-line tax deduction for the cost of LTC insurance premiums. The deduction would be available for the employee's share of the cost of employer-provided coverage if the employee pays at least 50 percent of the cost. The deduction would start phasing in 2004 and by 2007, taxpayers could deduct 100 percent of their long-term care premium costs. The federal proposal is projected to cost $21 billion over 10 years.[11]

Since Medi-Cal already is paying for the majority of nursing home costs in California (51 percent), LTC insurance is the only factor that potentially can reduce government's role in financing nursing home care.

California Partnership for Long-Term Care

In order to support expanded use of LTC insurance by Californians, DHS established an innovative program, the **California Partnership for Long-Term Care**, in cooperation with a select number of private insurance companies. These companies offer high quality policies that must meet stringent requirements set by the Partnership and the State of California.

"A revenue source in its infancy, long-term care insurance generates a very small portion of nursing facility revenue.

Very few aging Americans buy private long-term care health insurance and when they do it is often initiated at an advanced age—defeating the purpose of the insurance design.

Inevitably, unless this trend is reversed, likely through changes in tax policy, the growing financing burden will remain on the taxpayer base and present rapidly increasing fiscal pressures on the public programs—Medicare and Medicaid."

—CMS Health Care Industry Market Update Nursing Facilities (2/6/02).

The Partnership's LTC policy offers incentives to individuals to secure long-term care coverage. When the policyholder needs care, the policy pays for the care in a manner similar to those used by other high quality long-term care policies. In addition, however, for each dollar the policy pays out in benefits, it also entitles the policyholder to keep a dollar of assets should she or he ever need to apply for Medi-Cal services.

The Partnership seeks to protect policyholders from having to spend down assets, and it seeks to protect those assets from Medi-Cal estate recovery. It also is actively pursuing other efforts to increase penetration as a way to develop and strengthen a different funding source other than Medi-Cal:

- A new brochure published and aimed at adult children to consider how their parents' lack of LTC insurance will affect them should their parents need LTC.
- An Invitation to Participate to procure assistance marketing the Partnership's product to middle-income consumers via the work place. The State of California as an employer now offers a LTC policy to state, county employees, and other civil servants.
- The Partnership is also working closely with provider organizations, such as California Association of Health Facilities (CAHF) in joint consumer education efforts.

Implications

Government licenses all nursing homes, pays for the majority of nursing home care in this country, and regulates to prevent fraud and abuse and to ensure quality care. State and federal nursing home regulators are now implementing systems for quality of care oversight and reimbursement, that focus on the same quality data insurers need to evaluate the risks involved in providing liability insurance coverage to those same nursing homes.

The nature of the insurance industry is to gain predictability and consistency. By further integrating performance and quality improvement into its nursing home monitoring and oversight system, Medicare and Medi-Cal will be providing information useful to evaluating positive performance of nursing homes in the areas of quality and staffing. This more complete profile of provider performance can assist not only consumers, but also the insurers who provide liability coverage. Currently the main data available on nursing homes relates to negative performance and enforcement remedies.

TABLE 4.

CALIFORNIA NURSING HOME TREND DATA

Nursing homes can be either freestanding (SNF), meaning that they are not a part of any other healthcare facility, or hospital based, meaning they are a distinct part within a general acute care hospital (DP/SNF). They can be for-profit facilities, meaning that they are investor-owned, not-for-profit, or operated by the government (state or local).

Nursing Home Ownership Type

Freestanding

	Facilities	Percentage	Beds	Percentage
Investor Owned	1,028	84.7%	104,171	87.9%
Not-for-Profit	179	14.8%	13,579	11.5%
Governmental	6	0.5%	751	.6%
Total	1,213	100%	118,501	100%

Hospital Based

	Facilities	Percentage	Beds	Percentage
Investor Owned	50	22.0%	1,609	13.1%
Not-for-Profit	129	56.8%	6,995	56.8%
Governmental	48	21.1%	3,716	30.2%
Total	227	100%	12,320	100%

Combined

	Facilities	Percentage	Beds	Percentage
Investor Owned	1,078	74.9%	105,780	80.9%
Not-for-Profit	308	21.4%	20,574	15.7%
Governmental	54	3.8%	4,467	3.4%
Total	1,440	100%	130,821	100%

Source: OSHPD Annual Utilization Reports for LTC Facilities and Hospitals (2001)

TABLE 4.

Facilities by Year

Freestanding

	1996	1997	1998	1999	2000	2001
Investor Owned	1,026	1,025	1,032	1,028	1,034	1,028
Not-for-Profit	187	180	175	171	172	179
Governmental	4	4	4	4	6	6
Total	1,217	1,209	1,211	1,203	1,212	1,213

Hospital Based

	1996	1997	1998	1999	2000	2001
Investor Owned	60	70	64	56	56	50
Not-for-Profit	148	149	154	144	147	129
Governmental	54	53	47	49	51	48
Total	262	272	265	249	254	227

Combined

	1996	1997	1998	1999	2000	2001
Investor Owned	1,086	1,095	1,096	1,084	1,090	1,078
Not-for-Profit	335	329	329	315	319	308
Governmental	58	57	51	53	57	54
Total	1,479	1,481	1,476	1,452	1,466	1,440

Source: OSHPD Annual Utilization Reports for LTC Facilities and Hospitals (1996-01)

TABLE 4.

Occupancy Rates by Year

Freestanding

	1996	1997	1998	1999	2000	2001
Investor Owned	86.5%	86.3%	84.9%	83.4%	82.5%	81.2%
Not-for-Profit	87.6%	86.6%	85.3%	86.3%	83.1%	81.6%
Governmental	79.9%	76.4%	84.4%	68.3%	60.8%	59.7%
Total	86.6%	86.3%	84.9%	83.7%	82.4%	81.1%

Hospital Based

	1996	1997	1998	1999	2000	2001
Investor Owned	73.4%	68.0%	69.9%	70.4%	60.4%	57.1%
Not-for-Profit	75.3%	74.9%	74.4%	73.4%	71.7%	66.2%
Governmental	86.1%	81.4%	86.7%	86.8%	82.3%	80.1%
Total	78.3%	75.8%	77.1%	76.9%	73.3%	69.1%

Combined

	1996	1997	1998	1999	2000	2001
Investor Owned	86.3%	85.9%	84.6%	83.2%	82.1%	80.9%
Not-for-Profit	83.4%	82.5%	81.4%	81.6%	79.1%	76.3%
Governmental	85.3%	80.8%	86.4%	84.3%	78.5%	76.6%
Total	85.8%	85.2%	84.2%	83.0%	81.6%	80.0%

Source: OSHPD Annual Utilization Reports for LTC Facilities and Hospitals (1996-01)

TABLE 4.

Licensed Beds by Year

Freestanding

	1996	1997	1998	1999	2000	2001
Investor Owned	102,437	102,587	103,521	103,974	105,161	104,171
Not-for-Profit	13,187	13,246	12,531	12,104	12,600	13,579
Governmental	1,177	547	547	547	751	751
Total	116,801	116,380	116,599	116,625	118,512	118,501

Hospital Based

	1996	1997	1998	1999	2000	2001
Investor Owned	1,613	2,074	1,914	1,649	1,671	1,609
Not-for-Profit	7,128	7,146	7,189	6,985	6,852	6,995
Governmental	3,780	3,798	3,475	3,497	3,587	3,716
Total	12,521	13,018	12,578	12,131	12,110	12,320

Combined

	1996	1997	1998	1999	2000	2001
Investor Owned	104,050	104,661	105,435	105,623	106,832	105,780
Not-for-Profit	20,945	20,392	19,720	19,089	19,452	20,574
Governmental	4,957	4,345	4,022	4,044	4,338	4,467
Total	129,322	129,398	129,177	128,756	130,622	130,821

Source: OSHPD Annual Utilization Reports for LTC Facilities and Hospitals (1996-01)

TABLE 4.

Patient Days by Year

Freestanding

	1996	1997	1998	1999	2000	2001
Investor Owned	32,367,700	32,253,066	32,010,046	31,580,031	31,761,391	30,957,649
Not-for-Profit	4,425,991	4,194,112	3,910,033	3,821,196	3,818,040	4,065,365
Governmental	159,960	152,559	168,589	136,434	167,012	163,570
Total	36,953,651	36,599,737	36,088,668	35,537,661	35,746,443	35,186,584

Hospital Based

	1996	1997	1998	1999	2000	2001
Investor Owned	415,711	503,324	509,546	434,659	364,376	334,361
Not-for-Profit	1,954,421	1,929,995	1,927,391	1,874,702	1,798,975	1,693,335
Governmental	1,161,144	1,138,048	1,103,483	1,119,568	1,072,921	1,057,420
Total	3,531,276	3,571,367	3,540,420	3,428,929	3,236,272	3,085116

Combined

	1996	1997	1998	1999	2000	2001
Investor Owned	32,783,411	32,756,390	32,519,592	32,014690	32,125,767	31,292,010
Not-for-Profit	6,380,412	6,124,107	5,837,424	5,695,898	5,617,015	5,758,700
Governmental	1,321,104	1,290,607	1,272,072	1,256,002	1,239,933	1,220,990
Total	40,484,927	40,171,104	39,629,088	38,966,590	38,982,715	38,271,700

Source: OSHPD Annual Utilization Reports for LTC Facilities and Hospitals (1996-01)

TABLE 5.

POLICY & REIMBURSEMENT CHANGES AFFECTING NURSING HOMES

Statute/Regulation	Federal/State	Authority	Summary	Reasons
Omnibus Budget Reconciliation Act of 1987 (OBRA 87)	Federal	Medicare Medi-Cal	Monitoring Approach • Outcome-based compliance measures • Focus on appropriate assessment and care planning • Responsive to residents' wishes, capabilities, and changing status • Consistent approach nationwide Reimbursement • Reasonable costs for services rendered	• Major public and media concern about poor quality treatment of some nursing home residents
SB 679, Mello (Chapter 774, St. of 1991) Elder Abuse Civil Protection Act (EDACPA)	State	All Long-Term Care	Cases of Elder Abuse • Reasonable attorney's fees and costs • General damages for a decedent's pain and suffering ($250,000 cap) • Exception to Probate Code, allowing damages for a decedent's pain and suffering • Provisions for punitive damages	• Recognition that Medical Injury Compensation Reform Act of 1975 (MICRA) contained provisions that discouraged elder abuse litigation actions
New Federal Regulations (1995) to implement OBRA 87 Requirements	Federal	Medicare Medi-Cal	Resident Assessment Instrument (RAI) • A standard assessment protocol to identify residents clinical, care, and social needs • Minimum Data Set (MDS), a core set of elements that form the foundation of comprehensive assessment Enforcement • Standard enforcement terminology (scope and severity) • Additional enforcement remedies • Revised standard survey processes to determine applicable action	• Improve quality and consistency of the resident assessment process • Improve consistency of enforcement • Encourage compliance through variety of sanctions.

TABLE 5.

POLICY & REIMBURSEMENT CHANGES AFFECTING NURSING HOMES

Statute/Regulation	Federal/State	Medicare/Medi-Cal	Summary	Reasons
Balanced Budget Act of 1997 (BBA)	Federal	Medicare	Prospective Payment System (PPS) • Payments changed to prospective rate • Per diem payment for each Medicare resident, adjusted to reflect differences in resident characteristics and service needs	• Curb escalating health care costs
New Federal Regulations (1998) to Implement OBRA 87 Requirements	Federal	Medicare Medi-Cal	MDS • Automated transmission of resident assessment data • Begin phase-in of PPS • Some states use MDS/PPS in their Medicaid rate system	• Utilize data to streamline survey process • Focus on poor performing facilities • Create quality indicators that build acuity into monitoring systems • Enable calculation of rates consistent with acuity of residents
AB 1107 (Chapter 146, St. of 1999)	State	All SNFs	• Increased minimum nursing staff requirement to 3.2 hours of direct patient care per day effective January 2000	• Improve quality of care in nursing homes
Balanced Budget Refinement Act (BBRA) of 1999 Benefits Improvement and Patient Protection Act (BIPPA) of 2000	Federal Federal	Medicare Medicare	• Temporary “add-ons” for some per diem reimbursements for nursing homes • Include a temporary increase of 20% for 15 categories of residents, largely addressing medically complex patients • Many of “add-ons” sunset September 2002	• Mitigate the severity of the rate reductions caused by PPS

TABLE 5.

POLICY & REIMBURSEMENT CHANGES AFFECTING NURSING HOMES

Statute/Regulation	Federal/State	Medicare/Medi-Cal	Summary	Reasons
AB 1731 (Chapter 451, St, of 2000)	State	All SNFs	• Empower Consumers & Their Families ⇨ Enhanced Complaint System ⇨ Health facility information on internet ⇨ Increased posting of enforcement actions • Supporting Caregivers ⇨ Budget increases for nursing homes to benefit caregivers and improve quality of care ⇨ Increase focus on minimum staffing standards ⇨ Technical assistance to nursing homes to improve quality ⇨ Quality awards to nursing homes that provide exemplary care • Enforce Tough Licensing Standards ⇨ Facility reporting of alleged or suspected abuse within 24 hours ⇨ Facility financial reporting requirements ⇨ DHS Financial Solvency Advisory Board ⇨ Increase fines for violations of licensing standards ⇨ Increase frequency and unpredictability of surveys ⇨ Establish temporary manager enforcement option	• Improve quality of care • Acknowledge relationship between staffing and quality of care • Acknowledge the importance of incentives to support quality performance • Acknowledge the importance of protecting residents from abuse • Acknowledge the relationship between financial stability and quality care

TABLE 5.

POLICY & REIMBURSEMENT CHANGES AFFECTING NURSING HOMES

Statute/Regulation	Federal/State	Medicare/Medi-Cal	Summary	Reasons
AB 1075 (Chapter 684, St. of 2001)	State	All SNFs	• Create mechanism to increase minimum staffing requirements to level that assures high quality care • Require staffing standards to be converted from hours per patient day to a ratio of patients per direct caregiver. • Implement a facility specific Medi-Cal reimbursement system.	• Improve quality of care • Easier for residents and their families, facility employees, and state inspectors to monitor for compliance. • Rates that reflect costs and staffing levels associated with quality care.

[1] *Social Security Act,* Section 1819 (b)(2).
[2] The Health Unit*,* op.cit.
[3] Jane Tilly, et.al., *Long-Term Care: Consumers, Providers, and Financing - A Chart Book, Urban Institute* March 2001. pp. 34,36.
[4] "HHS to Provide Nursing Home Quality Information to Increase Safety and Quality of Nursing Homes" (press release), *HHS News*, U.S. Department of Health and Human Services, November 19, 2001. www.hhs.gov/news/press.
[5] Tommy Thompson, "Letter to The Honorable J. Dennis Hastert, March 19, 2002. nccnhr.newc.com//uploads/H&Hmarch19.
[6] Carole Fleck, "Nursing Home Care is Found Wanting," in *AARP Bulletin,* Washington, D.C., April 2002, p. 7.
[7] "Nursing Home Liability Insurance Rates: Factors Contributing to the Rate Increases in Texas," *Brief,* Senate Research Center, Austin, TX, February 2001, p. 5.
[8] *Nursing Homes Aggregate Medicare Payments are Adequate Despite Bankruptcies,* U.S. General Accounting Office, GAO/T-HEHS-00-192 (Washington D.C.: GPO, 2000), p.1.
[9] Cartwright, op.cit.
[10] Johnson, op.cit.
[11] "The President's FY 2003 Budget," *Federal Activities Report,* CalPERS, April 23, 2002, www.calpers.ca.gov/whatshap/legislat/activities .

IV. ENFORCEMENT AND CIVIL LAW

DHS seeks to protect and improve the health of all Californians. For the elderly, DHS ensures that nursing homes comply with federal and state requirements related to quality of care through its extensive oversight and enforcement activities. When an individual resident experiences poor or abusive care in a nursing home, that resident may notify DHS through its complaint process, initiating a review of the incident that can result in enforcement remedies. State options could include corrective action by the facility, fines, Medicare or Medi-Cal payment restrictions, or criminal action against the facility.

> "The Legislature further finds and declares that infirm elderly persons and dependent adults are a disadvantaged class, that cases of abuse of these persons are seldom prosecuted as criminal matters, and few civil cases are brought in connection with this abuse due to problems of proof, court delays, and the lack of incentives to prosecute these suits."
>
> *–Welfare and Institutions Code, Section 15600 (h)*

The resident also has the right to pursue a private cause of action under civil law against the facility. A nursing home seeks liability insurance coverage as protection for the financial solvency of its operations should such civil action claims be filed. Currently, no statute requires facilities to notify DHS or any other government agency when a civil suit is filed against them alleging poor or abusive care.

From the perspective of the insurance market, providing liability insurance for nursing homes carries a higher degree of risk than in previous years. Companies that continue to write general and professional liability insurance in California have increased premiums and included more restrictive terms relative to the nature of the risk.

Health facility organizations believe that difficulties in securing liability insurance may lead to a decrease in the number of nursing homes and other residential care facilities. If such decreases were to occur, access to residential options for consumers would be affected. Providers believe the number of civil litigation cases being filed against facilities is the major reason for the problems with the availability and cost of liability insurance. Consumer organizations, on the other hand, believe facilities can manage

their risk by providing adequate quality of care. They also believe that limits should not be placed on the nursing home residents' rights to have an adequate legal remedy for poor care.

LEGAL ACTIONS COVERED BY LIABILITY INSURANCE

Available Data

This section discusses **medical malpractice** law, elder abuse law, Medicare/Medicaid fraud and abuse law, and legal enforcement remedies affecting the cost and availability of liability insurance for nursing homes. It should be noted, however, nursing homes are not required to notify DHS when civil actions are filed against them or to update DHS on the status of such actions. The data regarding the extent of legal activity is limited.

DHS has determined that Section 1305 of the H&S Code currently includes a requirement for liability insurers to report at least annually to DHS regarding claims activity against nursing homes. Insurers are to report any final judgment or settlement over $3,000 rendered against a facility for which they are providing liability insurance coverage. Although this language has been part of the H&S Code for 30 years, DHS found no documentation to indicate that the provision was implemented. The language in the H&S Code is similar to provisions in Section 801 of the Business and Professions (B&P) Code that requires every insurer providing professional liability insurance to physicians, to report to the California Board of Medical Quality, any settlement awards over $3,000 or a claim or action for damages for death or personal injury caused by the physician's negligence, error or omission in practice or rendering of unauthorized professional services.

The Medical Board of California received over 900 reports regarding physicians and surgeons. On Oct 1, 2002, Governor Davis signed SB 1950 into law, a bill that requires the Medical Board to disclose more information to the public about doctors who have settled a series of malpractice claims.

Liability Insurance Claims

Nursing home general or professional liability insurance normally pays for the damages and defense expenses resulting from a negligent act, error, or omission in caring for a nursing home resident. If a resident or the resident's family pursues a private civil action related to one of these categories, the standards of proof required and the remedies available can vary (see Appendix E for detail regarding the laws discussed in this section).

A recent American Health Lawyers Association seminar on Long Term Care and the Law, referenced potential financial loss sources for LTC facilities to be considered in a facility's risk management focus as:

- Abuse
- Falls

- Decubitis (Pressure Sores)
- Elopements
- Family Communication
- Documentation. [1]

Damages are the monetary compensation or indemnity that may be recovered by an individual or entity that has suffered loss. Damages also vary according to the type of civil action pursued. The types of damages pertinent to a discussion of liability insurance for nursing homes include:

- **Compensatory-** Compensation for a plaintiff's documented out-of-pocket expenses that result from injury or damage; for example, loss of earning or medical expenses.
- **General-**Compensation paid for harm for which no specific evidence of financial loss is required because such harm—for example, **pain and suffering**—is presumed to have occurred from the nature of the event.
- **Exemplary-**Compensation over and above property loss when the act is from malice—for example, wrongful acts, aggravated negligence, but not criminal.
- **Punitive-**Amount of money awarded by a court to "punish" the defendant for acts of gross negligence or outrageous conduct, normally intentional, irrespective of the amount of actual or compensatory damages.[2]

AB 1XX (MICRA legislation)…
"Will affect malpractice-insurance premiums only indirectly. If the net effect is to improve the quality of health care and expedite the handling of malpractice cases while limiting the magnitude of the awards, the insurers' risk should diminish; and if risk diminishes, premiums should cost less. But the legislation's only direct effect on premiums would be through a provision empowering the state insurance commissioner to review, and even roll back, any premium increase exceeding 10 percent."

–"The Malpractice Bill: Neither a Placebo nor a Panacea," *California Journal,* October 1975

Medical Malpractice Laws in California

California's first experience with controversial debates on the issue of medical liability occurred in the early 1970s. Physicians' insurance premiums soared due to multi-million dollar medical malpractice awards; sharp increases in the number of claims filed and damage awards granted, and widespread media coverage. In 1975, major legislation was enacted in California to address the problem.

The Medical Injury Compensation Reform Act (MICRA)

MICRA instituted several major changes to medical liability statutes:

- limited to $250,000 the amount of non-economic losses an injured patient could recover to compensate for pain and suffering;
- cut the time limit for filing cases from four years to three;
- created a scale of "contingency fees" for attorneys based on the amount of the award (the higher the judgement, the smaller the percentage for the attorney); and
- Required 90-day notification of intent to sue.

Passage of MICRA did not eliminate debate regarding medical liability issues. During the period after MICRA, other laws were introduced that affected civil legal actions that might be taken against nursing homes that could affect their liability coverage.

Civil Liabilities Reform Act–Punitive Damages

In 1987, the State Legislature passed the Civil Liabilities Reform Act, which in part, amended civil procedure governing exemplary and punitive damages in tort litigation (Civil Code 425.13). Punitive damages were created by the courts to punish defendants for egregious conduct and, by setting an example, to deter others from similar conduct.

The law specifies procedural and substantive requirements that must be met before a punitive damages claim may be asserted. Punitive damages may not be covered by liability insurance. If such acts are deemed to be "willful," Section 533 of the Insurance Code prohibits the coverage. Providers argue that the high dollar amounts for punitive damages against nursing homes affect the willingness of insurance companies to write LTC liability policies, regardless whether or not the insurer carves out the coverage for punitive damages.

LAWS AFFECTING THE ELDERLY

While MICRA and subsequent reforms addressed important provider issues related to medical malpractice litigation, older Americans were beginning to identify serious limitations in the law that affected their ability to pursue judicial relief.

Federal Older Americans Act

Congress passed the Older Americans Act in 1965 to protect the rights of the elderly and encourage individual states to promulgate elder rights laws. In 1992 Congress added the Vulnerable Elder Rights Protection Program to the Act, providing federal funding for national and local elder rights programs aimed at reporting and preventing elder abuse.

OBRA 87 Protections

As discussed in Section III. Quality of Care Oversight and Reimbursement, OBRA 87 also initiated major changes, establishing a framework to ensure nursing home residents will receive quality services when their care is paid for by Medicare and Medicaid.

In 1991, significant amendments were made to the Code of Federal Regulations (CFR) identifying specific requirements to ensure resident rights in a facility. A resident "has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility," according to 42 C.F.R. Section 483.10. A lengthy list of requirements is included in the regulation.

California—Elder Abuse Civil Protection Act (EDACPA)

During the '70s and '80s, concerns for the treatment of nursing home residents were not only being addressed at the national level. In California, The Little Hoover Commission

demonstrated continued concern with the quality of life of California's elderly population in general, and its nursing home population in particular. The Little Hoover Commission on California State Government Organization and Economy is an independent, State oversight agency that was created in 1962.

The Commission's mission is to investigate state government operations and –through reports, recommendations and legislative proposals—promote efficiency, economy, and improved service. In a 1983 Commission report entitled *The Bureaucracy of Care, Continuing Policy Issues for Nursing Home Services and Regulation,* the Commission extensively studied conditions in California nursing homes and made a series of recommendations that led to the enactment of the Nursing Home Patients' Protection Act (NHPPA) of 1985.[3]

In 1991, SB 679, (Mello, Chapter 774, Statutes of 1991), or EDACPA, significantly modified existing California law for elder abuse cases, including enhanced remedies to award attorney's fees and specified damages in defined cases. Prior to that time, although abused elders or their conservators could, under MICRA, sue someone who had financially or physically abused them and be compensated for pain, suffering and other losses, two barriers made such cases difficult to win:

- The abuser did not have to pay for the victim's suffering if the victim died before a lawsuit was filed and a guilty verdict was issued.
- Few attorneys would take abuse cases, due to the difficulty of trying them and the risk in taking a case in which a fee would not be collectable.

The legislative intent of EDACPA recognized that elders and dependent adults may be subjected to abuse, neglect, or abandonment and that the State has a responsibility to protect these persons. The specific changes were:

- definition of the circumstances in which the resident (or elderly in other situations) could file under EDACPA;
- reasonable attorneys fees and costs;
- general damages for pain and suffering, in an amount no greater than $250,000;
- an exception to Probate Code Section 573, to allow damages for pain and suffering even after the resident's death; and
- Punitive damages under specific circumstances that demonstrated inappropriate action by an employee and advance knowledge or conscious disregard on the part of the licensee.

Other Laws Related To Elder Abuse and Care Issues

Federal and State False Claims Act

The purpose of the Federal False Claims Act, and the State False Claims Act is to find liability against persons who submit fraudulent financial claims against the government. A person who reports an action under either of these acts is known as a ***"Qui-Tam Relator."*** Reduction of fraudulent billing is a main objective of the legislation, but successful cases have been filed under the Act for provision of poor quality care by a health facility. To be reimbursed for Medicare or Medicaid services, health providers

certify that they will comply with the written standards for quality care. If the care can be proved substandard, the reimbursement claims submitted were false.

In 1986, Congress sought to strengthen its *qui tam* provisions to support government efforts to reduce fraud and abuse in public programs. The *qui tam* changes included:
- a share of 15-30 percent of the funds recovered in a successful case;
- reasonable attorney's fees and expenses; and
- Protection of whistleblowers from employer retaliation.

Federal Authority

The OIG for DHHS has primary authority for protecting the Medicare Program and its beneficiaries. In addition to various enforcement initiatives, OIG also utilizes several programs that rely on collaboration, cooperation and voluntary compliance on the part of the health care industry to fight health care fraud and abuse.

On March 16, 2000, OIG published its voluntary Compliance Program Guidance for Nursing Facilities in the Federal Register. The guidance contained seven elements OIG determined to be fundamental to an effective compliance program:
- implementing written policies, procedures and standards of conduct;
- designating a compliance officer and committee;
- conducting effective training and education;
- developing effective lines of communication;
- enforcing standards through well-publicized disciplinary guidelines;
- conducting internal monitoring and auditing; and
- Responding promptly to detected offenses and developing corrective action.[4]

Although the guidance information is not mandatory, the OIG also has "Corporate Integrity Agreements" (CIAs) that it can use as part of settlements or other investigations or audits arising under a variety of false claims statutes. A provider consents to the agreement in exchange for being able to continue billing under the Medicare program. Key elements of the agreements include the provider hiring a compliance officer and engaging an Independent Review Organization (IRO), such as an accounting, auditing, or consulting firm, to assess the adequacy of the provider's performance under the CIA. OIG held a roundtable discussion with providers operating under CIAs in July 2001. Overall, providers indicated they would continue to operate compliance plans and retain compliance officers after their CIAs expire.[5]

State Authority

The California Bureau of Medi-Cal Fraud and Elder Abuse within the Office of the Attorney General has responsibility to investigate and prosecute those who abuse and neglect patients in Medi-Cal-funded facilities such as nursing homes, developmental treatment facilities, and hospitals. DHS works closely with the Bureau on elder abuse cases. Whenever DHS receives a complaint that alleges abuse, neglect, or misappropriation of resident funds or property, DHS notifies and faxes a copy of the complaint to the Bureau upon receipt. DHS continues to investigate the complaint and provides documentation and assistance should the Bureau decide to prosecute.

The Bureau comprises three programs designed to bring increased accountability to those who abuse California's elderly population:

- ***Violent Crimes Unit–***investigates and prosecutes physical elder abuse committed by individual employees against patients in elder care facilities;
- ***Facilities Enforcement Team***– investigates and prosecutes corporate entities such as skilled nursing homes, hospitals, and residential care facilities, for adopting policies that lead to neglect and/or poor quality of care; and
- ***Operation Guardians–***conducts surprise, on-site inspections of nursing homes to identify and correct violation of laws designed to protect elderly patients.

The Bureau of Medi-Cal Fraud and Elder Abuse relies upon many statutes in criminal and civil prosecutions of Medi-Cal fraud and elder abuse (see Appendix F).

State Enforcement Actions (See inset). DHS, in its role as licensing agency for all nursing homes in California, and representing the federal government for Medicare and Medicaid certification, has substantial legal authority to ensure quality nursing home care.

ENFORCEMENT ACTIONS RELATED to ELDER ABUSE and CARE ISSUES

DHS, both as the licensing agency for the State and as the oversight agency representing the federal government for Medicare and Medicaid certification, monitors nursing home compliance with laws and regulations.

- The 2567 form, documentation DHS prepares as the basis to report and document its sanctions, is often used as evidence in civil cases against nursing homes.
- Complaints filed against facilities are often used as evidence in civil cases
  - ✓ 1/1/01-12/31/01: 8,614 complaints and **facility-reported occurrences** (26%)
  - ✓ 1,488 were for neglect/abuse (48% facility-reported occurrences)
- Sanctions available include:
  - ✓ directed plan of correction (POC),
  - ✓ directed in-service training,
  - ✓ denial of payments for new admissions,
  - ✓ denial of payment for all residents,
  - ✓ state monitoring,
  - ✓ **civil money penalties (CMPs)** (state and/or federal)
    - 7/1/00-6/30/01: Federal CMPs imposed over $1.5 million for 87 actions
    - 1/1/01-12/31/01: State citations assessed over $4.6 million for 1006 citations
  - ✓ temporary suspension of a license (state)
  - ✓ license revocation (state)
  - ✓ termination (federal)
  - ✓ receivership (state)
- Federal and state statute and regulation specify due process provisions for all actions
- Disciplinary actions against certified nurse assistants (CNAs) result in their de-certification
  - ✓ 7/1/98-3/1/02: over 275,000 CNA/HHA applications processed
  - ✓ 7,889 certifications denied or revoked for convictions (3.7%)

The **Form 2567** that DHS prepares as the basis to report and document its sanctions, and the **citation** (state monetary penalty) are public records. DHS enforcement documents may be used to support or dispute allegations. The **Plan of Correction (POC)** the facility submits, however, cannot be used in a legal proceeding as an admission against the facility, unless allowed by the court.

EFFECT OF LEGAL ENVIRONMENT ON LIABILITY INSURANCE FOR NURSING HOME INDUSTRY

MICRA and EDACPA form a strong foundation of civil law in California. Both recognize the importance of health and safety considerations for all citizens, and the right of individuals, especially the elderly and dependent, to protection from abuse and neglect.

MICRA prescribed parameters for civil actions at a time when the Legislature determined that escalating malpractice insurance costs threatened access to medical treatment for California citizens. The EDACPA protections for the elderly were successful in their objective to ensure that a victim of abuse could find an attorney to handle her or his case. Medi-Cal fraud and abuse litigation involved facility employees and recipients of government financed health care in legal proceedings aimed at reducing fraud and abuse by health facilities.

The public perception of care provided in nursing homes, however, continues to be increasingly negative. Litigation, monetary awards, and federal and state investigations of poor quality care, even abuse, communicate an inherent risk to residing in nursing homes.

Insurers, who in the past provided general and professional liability coverage for the long-term care industry, are determining the risk element for the nursing home industry is too unpredictable to be profitable. These insurers are either exiting the market or providing much more stringent and limited coverage.

CNA, one of the large admitted insurers in California still writing liability insurance for nursing homes, provided the following assessment to explain increases in claims severity and claims frequency trends:

> "The impact of state statutes intended to clarify the rights of long-term care facility residents…and their application in a litigious environment has affected the climate with respect to this business segment."[6]

RELEVANT CASE LAW

The passage of MICRA and EDACPA did not resolve the controversy related to what civil law protections are appropriate for elderly recipients of health care services. Several of the significant court decisions are summarized as follows:

MICRA

The validity of MICRA was tested in *Hoffman v. U.S., C.A.*9 (Cal.) (1985). The Court found that MICRA was supported by a rational basis, and did not violate the equal protection clause of the Federal Constitution. Reduction of medical malpractice premiums was a legitimate state purpose, and it was reasonable to believe that placing a ceiling on non-economic damages would help reduce such premiums.

The California Supreme Court upheld the constitutionality of damage awards limits and collateral source rules in *Fein v. Permanente Medical Group* 695P.2d 665 (1985). In *Fein,* the court stated that the Legislature was responding to an insurance crisis in the medical malpractice area, and therefore limiting non-economic damages to $250,000 under MICRA was rationally related to a legislative purpose.

Periodic payment of damage awards was upheld in *American Bank and Trust Co. v. Community Hospital of Los Gatos. Saratoga, Inc.* 683 P.2d 670 (1984). MICRA attorney fees statute was upheld in *Roa v. Lodi Medical Group, Inc.,* 211 Cal. Rptr 77 (1985).

EDACPA

The application of MICRA under the EDACPA was analyzed in *Kay Delaney v. Calvin Baker, Sr.,* 20 Cal.4th23, (1999). The California Supreme Court examined the relationship between the heightened remedies available under EDACPA and the application of MICRA to actions based on professional negligence. The court determined that if the plaintiff can meet the requirements under the EDACPA for bringing a cause of action, they are entitled to those enhanced remedies, despite the MICRA statutes that may govern individual cases of professional negligence.

Punitive Damages

In *Neal v. Farmers Insurance Exchange, (*1978) 21 Cal.3d 910, 927-928 (Neal), the court stated that:

> "Punitive damage award would be reversed only when it appears excessive as a matter of law or where it is so grossly disproportionate that it raises the presumption the award was the result of passion or prejudice."

In making that determination, the court considers: (1) the reprehensibility of the defendant's conduct; (2) the amount of compensatory damages; and (3) the defendant's wealth.

The federal standard applied to reversing a punitive damage award was examined in *BMW of North America v. Gore, (*1996) 517 U.S. 559, 562, 574 [134 L.Ed.2d 809, 825-826] (BMW). The court found a punitive damage award would be reversed if "the award violated the 14th Amendment's prohibition against arbitrary or excessive punishment of tortfeasors. The court would look at the amount of punitive damage award with the civil penalties authorized or imposed in similar cases.

Covenant Care, Inc. v. Superior Court of Los Angeles County, (2001) 107 Cal.Rprt.2d 291, is now under review by the California Supreme Court. The question relates to whether Civil Procedure Section 425.13 that governs claims for punitive damages against health care providers sued for "professional negligence," also applies to claims of "abuse or neglect" asserted against them under EDACPA.[7]

CONTESTED LEGAL ISSUES

Nursing home providers and insurance industry representatives see several factors behind the increased cautiousness in underwriting the nursing home business. Consumer and resident advocates tend to view the issues from a different perspective.

- **Does EDACPA encourage litigation and erode the damage limitations afforded in MICRA?**

Insurance Industry/Nursing Home Providers:

- ✓ EDACPA, intended to ensure elders appropriate access to legal services, is so open-ended that it makes virtually every facility in the state a ready target for litigation.
- ✓ The punitive damage provisions are ineffective in limiting use of the provisions. Punitive damage claims are routinely filed against nursing homes. Full court review should be required before allowing a pleading for punitive damages against a facility.
- ✓ More law firms are beginning to specialize in elder abuse cases, advertising on the Internet and teaching "how to" seminars across the country.
- ✓ Provision in EDACPA for billing of attorneys' fees is being misused. The provision encourages over-billing.
- ✓ The relationship of the licensee to facility staff is presented as "custodial" rather than "professional" in nature to avoid MICRA requirements.

Consumer/Resident Advocates:

- ✓ EDACPA is specific in defining what constitutes an abuse case under the Act.
- ✓ The burden of proof is similarly specific for punitive damages.
- ✓ Liability insurance is being used as an excuse for tort reform that allows facilities to get away with abuse and poor quality care.
- ✓ Facts do not support the assertions of increased litigation.
- ✓ The nursing home industry should put pressure on substandard providers to improve quality or get out of the business.

- **Is regulatory information inappropriate for use in medical liability cases?**

Nursing Home Providers:

- ✓ Survey findings are unreliable in many instances.
- ✓ Regulatory information with no direct connection to a case is used to prejudice the jury.

Consumer/Resident Advocates:

- ✓ Survey and enforcement records of a facility are often used to establish a pattern and practice of poor care. Without this information, any abuse or neglect case can look like an isolated incident.

Regulatory Perspective:

- ✓ The function of survey and enforcement records is to protect the health of Californians. It is the public policy to require remedial or corrective action on the part of the facility, once deficient practices or a violation has been identified.

Implications

Provider and insurance industry representatives believe that state statutes such as EDACPA, originally intended to clarify the rights of LTC facility residents, "and their application in a litigious environment, have affected the climate with respect to this business segment."[8] Consumer attorney and advocate organizations feel that "California nursing home verdicts encourage decent care and are a vital check to balance the system." [9]

A review of available data reveals that the State and DHS have little information on the affect of civil litigation in improving the quality of care in nursing homes. Although deterring abusive practices for future residents is often a reason cited by plaintiffs for litigation. In many cases, residents and their representatives settle with the nursing homes under confidential agreements that are known only to the parties. If quality improvement and resident protection are the goals of all stakeholders, then the effectiveness of certain aspects of current statute needs to be reviewed.

[1] Keith Becker, "Surviving the Long Term Care Liability Crisis: Key Strategies and Solutions," in presentation on *Long term care and the Law,* American Health Lawyers Association, February 2002.
[2] Pam Ahrens, *Risk Management Handbook,* Office of Insurance Management, Risk Management, State of Idaho, October 1999, p 86. www.state2.id.us/adm/insurance .
[3] *Report on the Medical Care of California's Nursing Home Residents: Inadequate Care, Inadequate Oversight,* The Little Hoover Commission, February 1989, p. 1.
[4] Federal Register, Vol. 65, No. 52, March 16, 2000, p. 14289.
[5] *Results of the Corporate Integrity Agreement Survey (Abstract),* Office of Inspector General, August 2001, p.1. www.oig.hhs.gov/fraud/cia.
[6] Hillary Lewis, Letter from CNA Insurance to DHS Licensing and Certification, January 17, 2002.
[7] Robert H.Moran, Letter from California Association of Health Facilities to the Department of Health Services, January 11, 2002.
[8] Lewis, op.cit.
[9] Cartwright, op.cit.

V. CONSUMER ACCESS TO QUALITY LONG-TERM CARE

Frail, ill residents of a health facility depend on that facility for shelter and for health services. For the safety of residents, a sudden, unexpected closure of their facility for financial reasons would require immediate action. Either DHS must arrange for satisfactory new owners and managers, or it must arrange timely transfer of residents to alternative nursing homes. Under either circumstance, DHS would supervise the situation on an around-the-clock basis until satisfactory arrangements are made for all residents.

If a nursing home loses or fails to maintain its liability insurance coverage, it places the facility at risk of bankruptcy or financial insolvency should civil litigation be filed against it.

The responsibility of government in the LTC market is to ensure that high quality services are provided by facilities, through a system of licensing and regulatory oversight and enforcement. In the event that a regulated facility closes, government is responsible for ensuring the rights of the resident continue to be protected.

Nine million Californians will be over the age of 60 by 2020. What continuum of care will be in place two decades from now? Will there be sufficient caregivers to support the available options? What information will assist Californians in their health decisions? Liability insurance for LTC providers is only one of a myriad of issues affecting the State's systems.

Aging baby boomers will continue to make LTC a potential growth market, if organizations determine the possibility for success in the market outweighs the potential risks. Access to and availability of LTC alternatives will depend upon consumer need, adequate funding, and qualified providers.

PROTECTION OF RESIDENT'S RIGHTS IN NURSING HOMES

Risk of Facility Closure

Nursing homes that cannot find a liability insurance carrier, or cannot afford the premium, may choose to operate without liability insurance ("going bare"). A facility that goes bare faces the greatest financial risk.

A number of State requirements have been enacted to alert DHS when a facility is experiencing a financial risk that could result in closure (see Table 5, Aging with Dignity, page 45). The goal of DHS is to avoid closing a facility whenever possible, for the sake of residents' health and safety.

The relationship between the **licensee** and the property owner will sometimes determine whether a change of ownership is possible rather than a closure. In some situations, DHS L&C staff is able to actively assist a facility to identify an appropriate new owner to enable residents to remain where they are. In enforcement actions, the situation may be so dangerous and unsafe for residents that closure is the only alternative.

If a facility intends to close, the facility must submit a relocation plan to the DHS L&C district office 45 days prior to the scheduled closure. If residents must be transferred to other facilities, the residents always must be given written notice 30 days in advance of the transfer, and the facility must assess residents for placement. DHS tracks the location of all transfer residents and conducts follow-up visits to determine any negative effect upon individual residents. Whenever a SNF is being closed, DHS always monitors the process very carefully. For example, DHS might conduct onsite supervision of the entire resident assessment and transfer process should it have concerns about health and safety of residents.

In June 2001, DHS experienced its first situation in which the licensee "abandoned" three facilities for financial reasons, without the prior notification process required in statute. In that situation, DHS' involvement was immediate. Using AB 1731 provisions, DHS hired a temporary manager to operate the facilities until new qualified providers could be licensed and assume operations. An appropriate new owner was found for two of the nursing homes, but could not be found for the third facility. DHS employees monitored activities in all the facilities during this time and ensured the safe and orderly transfer of residents was completed in the facility that closed.

The process for DHS to make permanent arrangements for residents of the three facilities required three months at a cost of over $2 million. DHS was able to pay for the emergency costs in this instance, using monies from the **State Citation Penalty Account.** This account contains money collected from state civil penalties imposed upon facilities. Money in the account must be used for the protection of the health or property of residents.

Although the financial failure and closures described here did not result from lack of liability insurance, any facility that "goes bare" faces a significant financial risk. With over 1400 nursing homes across the state, account funds are not sufficient to handle an unlimited number of such emergencies. Once the account is depleted, money from the State General Fund would be required.

Arkansas recently enacted legislation aimed at reducing liability insurance costs for nursing homes. When asked to describe the benefits of the legislation, the chief counsel for the state health department stated: "DHS [Arkansas' health department] does not want to be in a position of taking over failed nursing homes." [1]

PROMOTION OF LONG-TERM CARE ALTERNATIVES

California is home to an array of LTC programs. A December 2000, Medi-Cal Policy Institute report, "The Role of Medi-Cal in California's LTC System," documented more than 74 public LTC programs and related services housed in six state agencies, with expenditures of at least $13.5 billion in 1998. Within those programs, what constitutes a LTC facility also can vary depending on who uses the term and for what purpose.[2]

Nursing Homes

Many of the larger nursing facility and assisted living companies are publicly traded on the stock market. The nursing facility industry currently composes the largest part of LTC business, with national spending in 2000 of $92.2 billion.[3]

The steady trend in nursing home ownership has been towards corporate, freestanding, for-profit facilities.

The steady trend in nursing home ownership has been towards corporate, freestanding, for-profit facilities. Approximately 66 percent of the nursing home beds in the United States are owned by for-profit entities, and in California, the number is over 80 percent. Of freestanding nursing homes in the state, over 87 percent are for-profit.

Large chains constitute a significant portion of the nursing home industry. CMS identified ten nursing facility companies as owning 18.46 percent of the total beds nationwide.[4] Many of these same chains also own a significant number of SNF beds in California.

Nursing homes are both a type of housing unit and provider of health care. Corporate investors and owners, financial and business communities, view facilities as "properties" since they are a type of living arrangement. Financial transactions are decided based on such factors as stock prices, capitalization rates, investment potential, occupancy rates, profitability ratios and risk. From a business perspective, as long as the numbers demonstrate potential for profit, a future continuum of available long-term residential care appears viable.

In 1999, however, the business perspective for nursing homes did not appear viable. Five of the ten top chains by bed count in the country filed for bankruptcy within a relatively short period. Because of the large number of beds these companies represented nationwide, federal lawmakers were quick to schedule hearings to determine the potential impact on the industry. At a September 5, 2000, U.S. Senate hearing, "Nursing Home Bankruptcies: What Caused Them?" witnesses described many factors contributing to the bankruptcies. A number of the factors related to implementation of more restrictive Medicare rates, but another factor was identified as "litigation and related insurance costs."[5]

Many nursing home providers blamed changes in the PPS for their financial difficulties. Congress responded by adopting temporary add-ons for some of the per diem reimbursement SNFs had lost under PPS. These add-ons sunset in September 2002 (see Table 5, page 45, BBRA). On January 17, 2002, the federal **Medicare Payment Advisory Commission (MedPAC)** expressed its intention to recommend that those add-ons end in September. Stock prices for publicly traded nursing facilities fell 12.9 percent on that day. Wall Street analysts expect that the availability of capital for expansion to serve the aging population is dependent upon federal policy decisions related to these add-ons.[6]

In March 2002, *Briefings on Long-Term Care Regulations,* a monthly periodical, reported:

> Many states are considering cutting Medicaid payments to cope with a growing financial crisis. For nursing homes, many of which rely on Medicaid to pay for nearly two-thirds of their residents' care, this could be
> a disastrous move. Due to declining revenues because of the recession and soaring Medicaid costs, many states are trimming Medicaid...[7]

The March 2002 issue of *The Senior Care Investor* voiced similar uncertainty:

> While we know what happened last year, it is unclear what will happen in 2002 because so much uncertainty remains in the market. One by one, states are talking about Medicaid reimbursement cuts while Washington debates what to do about some 'temporary' Medicare rate increases that are set to expire this October. [8]

Assisted Living Facilities

California has over 6,000 **Residential Care Facilities for the Elderly (RCFE)** with a total capacity of almost 140,000 beds. Eighty-five percent of these RCFEs have fewer than 16 beds. Large, for-profit facilities account for only a portion of the supply.[9]

According to the provider organizations that represent the assisted living market, liability insurance premiums and litigation are increasing for assisted living facilities. Private pay is the source of payment for most RCFEs, but many residents use a combination of the federal Supplemental Security Income (SSI) program with State Supplemental Payments (SSP) for rent payments. Major cost increases in liability insurance premiums will be reflected in the rates assisted living facilities charge to consumers.

Anne Burns Johnson, President and Chief Executive Officer, California Association of Homes and Services for the Aging (CAHSA), represents both nursing homes and other senior homes and services. In her recent testimony to the Joint Informational Hearing of the Senate Health and Human Services Committee and the Senate Subcommittee on Aging and Long Term Care, she said:

> The insurance industry's inability (or unwillingness) to separate out affordable housing raises the cost of liability coverage for all facilities, no matter how healthy, ambulatory, or vigorous the residents may be. As a result, not just nursing homes, but the entire spectrum of long term care is threatened by the skyrocketing cost of liability coverage.
>
> Huge increases in liability premiums jeopardize long-standing community based programs provided by our members. In the face of rising costs, members are struggling with decisions to continue services that have long been part of their mission and tradition; programs like the Brown Bag food for the poor. The daily Call-a-Senior Program for isolated elderly; free information and referral programs for families and seniors. All are at risk due to higher insurance costs.[10]

Implications

Health care in the United States is a business enterprise, and consideration must be given to balancing the viability of the business and the implications this has on access to care. At the same time, policy solutions should never ignore the fact that high quality care is good business. All stakeholders agree on the importance of providing high quality care to the elderly. Modifications to the current system to resolve immediate problems must be more than "quick fixes" and ensure that access to better care will also be an outcome of any change.

[1] Michael Rowett, "Panel Rejects Bill Shielding Nursing Homes," in *Arkansas Democrat-Gazette,* April 4, 2002.
[2] Harrington, op.cit, p 1.
[3] Scully, op.cit. p.6
[4] Ibid.
[5] Senator Charles Grassley, "Grassley: Bankrupt Nursing Home Chains Must Justify Funding Requests (Press Release)," September 5, 2000.
[6] Scully, op.cit., p. 3.
[7] "Medicaid Funding Takes Hit as Loophole Closes," *Briefings on Long-Term Care Regulations*, OPUS Communications, Vol. 10 No.3, March 2002, p. 2. www.snfinfo.com.
[8] "Acquisition Prices Stabilize in 2001, But Future Is Cloudy," *The Senior Care Investor,* Irving Levin Associates, Inc., Vol. 12, Issue 3, March 2002, p. 2.
[9] The Quality Initiative, *A Primer on Residential Care Facilities for the Elderly,* San Francisco: California HealthCare Foundation, January 2002, p. 7.
[10] Johnson, op.cit., p. 3.

VI. LIABILITY INSURANCE ISSUES IN OTHER STATES

A review of activities in other states is helpful in developing a list of potential actions that could be undertaken in California to address the cost and availability of liability insurance. Over 20 percent of the individual states either have recently introduced or enacted legislation that attempts to address cost and availability of liability insurance for nursing homes.

> "As liability premiums continue to soar, state policymakers appear to be considering the matter with careful scrutiny. Seeking a balance between strong resident's rights and adequate protections for the long-term care industry, legislators are aware of the enormous implications that actions such as tort reform and state funding for liability insurance can have on the interested parties, not the least of which are consumers, providers and states."
>
> -- Elizabeth Devore, NCSL Report, *Nursing Homes: The Escalating Liability Crisis.*

The National Conference of State Legislatures (NCSL), Health Policy Tracking Services, monitors legal actions across the nation related to medical liability (see Appendix G) and has begun to survey legislative action on liability insurance for nursing homes. Each state is unique, however, in its approach to seeking an appropriate balance between resident's rights and protections for the LTC industry.

Any comparison of activities in other states also must consider the LTC options available, the demographics of the state, and clinical aspects of resident care. All states license nursing homes and contract with the federal government to certify eligibility and conduct legal enforcement actions for Medicare and Medicaid. However, states also differ in approach because of policy priorities and program organization. Table 6 (page 76) summarizes legislative activities recently enacted or under consideration by other states, comparing them with California requirements.

Colorado, Pennsylvania, and Utah require SNFs to notify the state regarding liability insurance coverage. In those states, securing liability insurance had not been an issue in previous years. Pennsylvania, however, passed significant legislation on March 20, 2002 that would change its liability insurance requirements.

Florida, Texas, and Arkansas began experiencing high premiums and limited availability of nursing home liability insurance a few years ago and recently passed reform legislation targeted at containing insurance rates for nursing homes.

WHAT HAPPENED IN FLORIDA?

Florida's experience illustrates what can happen when civil litigation costs are high, liability insurance premiums are rising, and admitted liability insurers drop out of the market altogether. In 2000, Beverly Enterprises, the nation's largest operator of nursing homes, announced that it intended to sell all of its 49 nursing homes in Florida and four assisted living facilities. Beverly had experienced losses for increased liability insurance reserves related primarily to those Florida properties. The risks involved in doing business in the state outweighed the potential for profit.

Florida's legislature first attempted to modify its tort law for all businesses in 1997, but no legislation was passed. In 1998, Senate Bill 874 reached the Governor's desk but was vetoed because "it gave unfair advantage to big business, and did not adequately compensate innocent victims in its provisions".[1] In 1999, House Bill (HB) 775 was enacted. While this legislation included provisions to address liability coverage, it provided exceptions for cases involving abuse of disadvantaged persons and the elderly.

In January 2000, at the request of the Florida Health Care Association, Aon Worldwide Actuarial Solutions published an actuarial analysis of the cost of general liability and professional liability (GL/PL) claims to the long- term care industry operating in Florida. Providers included in the study were for-profit, multi-facility providers. The results of Aon's analysis showed that long-term care GL/PL costs in Florida were "higher than any other state (including Texas and California) in the United States." [2]

In May 2000, the Florida Legislature established the Task Force on Availability and Affordability of Long-Term Care (HB 1993). The Task Force was chaired by the Lieutenant Governor and comprised stakeholders and experts in the long-term care field. The Florida Policy Exchange Center on Aging (FPECA), University of South Florida, provided staff support. The charge of this group was threefold: to create a balanced long-term care system, improve nursing home quality of care, and contain the costs of litigation.

According to FPECA's "Overview of Staff Findings and Recommendations", the average size of a nursing home litigation claim in Florida was $278,637 in 1999, 250 percent more than the average claim in the other states ($112,351). [3] As of February 2001, Florida had no admitted insurance carriers (those regulated by the Department of Insurance) that would provide liability coverage for long-term care facilities. Surplus insurance carriers also had effectively stopped writing policies in the state.

Task Force members did not vote on the conclusions and recommendations included in the "Final Staff Informational Report" published January 28, 2001. The report is full of footnotes and clarifications identifying issues on which individual members questioned the findings and recommendations, and sometimes even the data used to describe the situation.[4]

The efforts of the Task Force, however, resulted in a comprehensive nursing home reform package, SB 1202, that addressed nursing home tort reform, liability insurance reporting requirements, nurse staffing standards, and other quality of care provisions (see Table 6, page 75). Other components of the package included creation of a Quality of Long-Term Care Facility Improvement Trust Fund to support quality initiatives, mentoring programs for direct care staff, specialized training for staff working with Alzheimers' residents, and incentives to enhance job stability and career development.

Evaluating the effectiveness of Florida's comprehensive reform package is difficult at this time, since most of its provisions have been in place for less than a year. In addition, some differences between Florida and California make direct comparisons difficult. Prior to 2001, Florida did not have elder abuse statutes. Elder abuse lawsuits were based on patient's rights causes of action, or infringing on the rights of the elderly. Many of the rights identified were vague and not properly defined. On the other hand, the terminology and burden of proof requirements for civil liability and elder abuse cases in California statute are quite specific.

The Florida Health Care Association commissioned a follow-up study by the Florida Policy Exchange Center on Aging at the University of South Florida to examine the extent of the liability insurance crisis in the state. That report, published in December 2001, found that on average, nursing homes were still paying nearly $150,000 in premiums to obtain, often only limited, liability coverage. Twenty percent of facilities were uninsured, 36 percent were self-insured and 28 percent did not expect to renew their coverage. [5] Legislation has been introduced in the 2002 Florida legislative session to open the Florida Residential Property and Casualty Joint Underwriting Association to nursing homes and assisted living facilities.

AB 1202 required nursing homes to maintain liability insurance at all times. Florida delayed enforcement of the requirement until January 1, 2002. LTC

industry representatives filed an appeal of the coverage requirement. Facilities found liability insurance either was not available or the costs were too high. On February 20, 2002, Florida established the House Select Committee on Liability Insurance for Long Term Care Facilities to review the issue further. [6]

The committee held two workshops, at which time experts and interested parties were invited to testify. A final report was issued on March 15, 2002. The committee concluded that:

> During the short time the Select Committee has reviewed the liability problem within the long term care sector, no consensus has emerged among the various organizations and interest groups participating in the debate over the existence, or nature, of a specific crisis, nor whether any immediate legislative or administrative solution should be applied.[7]

WHAT HAPPENED IN TEXAS?

The Texas Senate Research Center published a briefing document in February 2001, "Nursing Home Liability Insurance Rates: Factors Contributing to the Rate Increases in Texas." The report indicated that nursing homes in Texas were facing "unprecedented rate increases in their liability insurance premiums."[8] The legislative focus in attempting to resolve the situation centered on: nursing home surveys as evidence in civil lawsuits, Medicaid reimbursement rates, punitive damage caps, and a public rating system of nursing homes.

In June 2001, the Texas Legislature enacted SB 1839, the Long-Term Care Facility Improvement Act. Similar to Florida, Texas implemented a comprehensive package of changes to address liability insurance, the nursing home survey process, and quality improvement (see Table 6, page 76). The provisions included: for-profit nursing homes added to the facilities eligible to participate in the state's JUA, mandated liability insurance, the development of an "early warning system," and a Long Term Care Facility Quality Outreach Program. For the outreach program, the new legislation essentially shifted approximately 10 percent of the positions previously budgeted for surveyors and enforcement into a program that provides technical assistance and training to facilities to support quality improvement.

In December 2001, the Texas Department of Insurance (TDI) published a set of "best practices" guidelines aimed at reducing nursing home claims. Both insurance companies and the Texas Medical Liability Insurance Underwriting Association may consider a nursing home's adoption and use of the best practices in determining the nursing home's rates for medical professional liability insurance.

The "best practices" document sets forth guidelines directed at nine risk exposure areas: falls, resident abuse, pressure ulcers, nutrition and hydration, medication management, restraints, infection control, burns and scalds, and elopement. According to TDI, "[t]he best practices do not establish standards of care that could be used against a nursing home in a civil lawsuit. Rather, the emphasis is on procedures for minimizing insurance claims and, by extension, improving the quality of care received."[9]

Since many components needed to implement this legislation are still in the development stage, evaluation of the legislation's effectiveness is premature. For example, the TDI has created a tier-rating system of nursing homes that considers a number of factors that determine risk of insurability including:

- Past Claims Experience;
- Quality of Care Rating (An Online State Rating System);
- Staff Ratios
- Tenure and Credentials of Key Personnel;
- Risk Management, Loss Control, and General Safety; and
- Ombudsman Program Evaluation. [10]

At this time only one nursing home has obtained liability insurance under the JUA. Nursing homes have until September 2003 before they are mandated to carry liability coverage.

A recent article in the *Insurance Journal, The Property and Casualty Magazine of Texas,* reviewed the current status of nursing homes' efforts to obtain medical liability coverage. The article reported that while the Texas Department of Human Services anticipate that the liability insurance requirement may influence the market, other sources "say the legislature still has a lot of work to do before long-term problems are solved."[11] The Texas legislature meets every two years, and the next session will convene in January 14, 2003.

Medical Liability Market

On May 6, 2002, the Texas House Insurance Committee also met to review the status of the broader medical liability insurance market. While the discussion included both nursing home liability insurance and physician malpractice insurance, several items in the testimony of the Insurance Commissioner are of interest to this study:

- The number of companies writing medical liability insurance in Texas has dropped from 17 last year to 4 currently;
- From 1996 to 2000, the cost of insurance rose 15 percent;
- "Arizona and California perform consistently better [than Texas], while Florida's problem is consistently worse than Texas."[12]

ARKANSAS NURSING HOME LIABILITY INSURANCE POOL

Arkansas enacted the Nursing Home Liability Insurance Act in 2001. The state's Department of Insurance is now proceeding with plans to create a voluntary, liability insurance pool. A NCSL summary of the legislation states:

> The plan will provide coverage, on a per violation basis, that is limited to $1million per occurrence and a $3 million aggregate amount per year. Coverage will include actual damages, non-economic compensatory damages and defense costs, but not punitive damages and other standard exceptions in liability contracts.[13]

OTHER STATES

NCSL

According to NCSL, in 2001, Arkansas, Florida, Indiana, Massachusetts, Tennessee, and Texas initiated bills on the topic of liability insurance for nursing homes. In 2002, six states already have introduced specific legislative proposals related to nursing home liability insurance: Iowa, Massachusetts, Mississippi, Ohio, Pennsylvania, and Tennessee. [14]

Recent Pennsylvania Action

On March 20, 2002, the Governor of Pennsylvania signed into law the "Medical Care Availability and Reduction of Error Act." The Act applies to physicians, hospitals, and other medical providers. It included:

- Insurance reform- reductions in mandatory medical professional liability insurance amounts, and a phase-out of the existing catastrophic loss fund to be replaced by a similar "Mcare" Fund.
- Medical professional liability reform- caps on punitive damages, prohibition of duplicative recovery, and a statute of limitations.
- Patient safety- new requirements in the area of patient safety, including requirements for development of Patient Safety Plans.[15]

American Health Care Association (AHCA) Study

Aon Risk Consultants, Inc., at the request of AHCA, conducted an actuarial analysis of the cost of GL/PL claims to the LTC industry in the United States. The study was released on February 28, 2002. In addition to Florida and Texas, which had experienced the most significant GL/PL cost increases, Aon identified six other states that were experiencing similar cost trends: Georgia, West Virginia, Arkansas, Mississippi, Alabama, and California. [16]

Implications

The experiences of Florida, Texas, Arkansas, and Pennsylvania—states that implemented legislation to address liability insurance issues—attest to the complexity of tackling this issue. There are no "quick fixes" to improve the availability and cost of GL/PL insurance for nursing homes. Any solutions must be comprehensive in nature and implemented with the involvement of stakeholders who share the responsibility for ensuring the existence of a high quality system of long-term care for the future.

TABLE 6.

CALIFORNIA COMPARISON: NURSING HOME LIABILITY INSURANCE REFORMS
Adopted or Introduced in 2001-02 by Other States

(States in bold have enacted statutes)

Other State's Insurance Reforms	Existing California Statute or Process
▪ Insurers required to provide market information to insurance commissioner (**TX**)	▪ No requirement for routine provision of information related to liability insurance for long-term care providers.
▪ Insurance commissioner published best practices for risk management and loss control (**TX**)	▪ No best practices for risk management from insurance commissioner.
▪ Establish joint underwriting association (JUA) or other state sponsored risk pool for nursing homes (**TX**, **AR**, **PA**)	▪ No present authority to establish JUA.
▪ Use public bonding authority to capitalize risk pool or JUA reserves (**TX**)	▪ No present bonding authority.
▪ Medicaid waiver to use portion of Medicaid payment as capital for risk pool (**FL**)	▪ No Medicaid waiver for use as capital for risk pool.

TABLE 6.

CALIFORNIA COMPARISON: NURSING HOME LIABILITY INSURANCE REFORMS

Adopted or Introduced in 2001-02 by Other States

(States in bold have enacted statutes)

Other State's Civil Law	Existing California Statute or Process
▪ Persons claiming elder abuse violations bear burden of proof that breach of duty caused injury (**FL**)	▪ Existing definitions, burden of proof in EDACPA. Use "reasonable care" standard, (Section 15657 W&I Code).
▪ Presuit notice and waiting period for elder abuse claims (**FL**) → Prior notice 75 days before filing → Facility may conduct evaluation and respond in writing → Once claimant receives written response 30 days to meet in mediation → Claimant has 60 days to file	▪ No action based on professional negligence before giving 90 days notice (Code of Civil Procedure Section 364).
▪ Shortened statute of limitations for elder abuse claims (**FL**, **MS**, OH, **PA**) → Actions initiated within two years of discovery or incident's occurrence (exception to a maximum of six years)	▪ Statute of limitations three years or one year after discovery (with specified exceptions) for cases of professional negligence (Code of Civil Procedure Section 340). ▪ Statute of limitation one year for injury or malpractice or death of one caused by the wrongful act or neglect of another (Section 340)
▪ Caps or limits on punitive damages (**FL**, **OH**) → Punitive damages for intentional misconduct or gross negligence. → No greater than three times the compensatory damages awarded each claimant, or $1 million (specified exceptions)	▪ No punitive damages under MICRA (Civil Code Section 3333.2) → Exception under EDACPA when "clear and convincing standard" that demonstrates specific improper actions on the part of employee and employer (W&I Code 16657(c)).

TABLE 6.

CALIFORNIA COMPARISON: NURSING HOME LIABILITY INSURANCE REFORMS

Adopted or Introduced in 2001-02 by Other States

(States in bold have enacted statutes)

Other State's Civil Law	Existing California Statute or Process
▪ Insurers not liable for punitive damage awards if they decline to settle claims within policy limits (**TX**)	▪ Punitive damages not insurable in California if deemed to be "willful"(Section 533 of Insurance Code).
▪ Selection of survival damages or wrongful death damages (**FL**) → Cannot obtain both wrongful death and survival damages in cases where resident dies → Can recover costs of action but not damages	▪ EDACPA Cases → Can obtain both wrongful death and survival damages → Can recover costs of action and damages
▪ Limits on admissibility of licensing inspections and citations as evidence (**TX**, MS, **OH**)	▪ Licensing inspections and citations are admissible as evidence, **Statement of Deficiency** forms and citations are public documents. Facility Plans of Correction (POC) cannot be used as an admission of violation in legal proceedings unless court decides relevance.
▪ Limits on attorneys' fees (**FL**) → Repeals fees for injury or death fees → Caps fees at $25,000 for claims with a court order	▪ MICRA limits non-economic losses to $250,000, (Civil Code, Section 3333.2). → Exception under EDACPA which provides for "reasonable attorneys fees" (W&I Code, Section 16657(a))
▪ Elimination or curtailment of residents' rights violations as a cause of action (**OH**)	▪ EDACPA provisions include resident rights violations (W&I Code, Section 15657).
▪ Limits on pain and suffering damages (TN, **MS**)	▪ MICRA limits non-economic losses to $250,000 (Civil Code, Section 3333.2(b)).

TABLE 6.

CALIFORNIA COMPARISON: NURSING HOME LIABILITY INSURANCE REFORMS

Adopted or Introduced in 2001-02 by Other States

(States in bold have enacted statutes)

Other states' Licensing Reforms	Existing California Statute or Process
▪ Nursing homes required to maintain liability insurance (**FL**, **TX**, **PA**)	▪ No present requirement for nursing homes to maintain liability insurance.
▪ Nursing homes required to have risk management and quality assurance programs (**FL**)	▪ No specific requirement related to Risk Management and Quality Assurance (QA) Programs. → Federal law requires nursing home committee to identify issues applicable to QA and to develop and implement appropriate plans of action for identified quality deficiencies (42 CFR 483.75(o)) → State requires nursing homes to have a patient care policy committee (CCR Title 22, Section 72525); and a staff development program that addresses numerous risk management issues (CCR Title 2, 72517(a))
▪ Courts required to report punitive damages awards against long-term care facilities (**FL**, **TX**)	▪ No current DHS requirement.
▪ Establish quality of care monitors, separate from licensing inspectors (**FL**, **TX**)	▪ No equivalent to Texas system of quality care monitors. AB 1731, Governor's nursing home reform legislation, established a nursing home technical assistance unit, separate from licensing.
▪ Increased oversight of poor performing homes (**FL**)	▪ DHS conducted a two-year pilot program of focused enforcement that targeted 35 facilities. DHS intends to expand its focused enforcement effort to include up to 100 facilities.
▪ Publication of nursing home "watch list" for consumers to evaluate the quality of nursing homes. (**FL**)	▪ DHS does not publish a "watch" list.
▪ Establish facility "early warning system" based on financial and quality of care indicators (**TX**)	▪ AB 1731 created a Skilled Nursing Facility (SNF) Financial Solvency Advisory Board that will develop and recommend to the Director financial solvency licensing requirements and standards relating to the operation of SNFs.

TABLE 6.

CALIFORNIA COMPARISON: NURSING HOME LIABILITY INSURANCE REFORMS

Adopted or Introduced in 2001-02 by Other States

(States highlighted in bold have enacted statutes)

Other States' Quality Initiatives	Existing California Statute or Process
▪ Higher nursing home staffing standards for direct care workers (**FL**)	▪ 3.2 hours per patient day minimum standard (one of highest in nation). AB 1075 (2001) requires CA to convert to ratio and establish regulations by 2003.
▪ New training requirements for Certified Nurse Assistants (CNAs) (**FL**)	▪ AB 1731 (2000) increased classroom hours required for CNA pre-certification program from 50 to 60 hours. Requires DHS to develop a standardized CNA curriculum, review the current examination process and develop a plan that identifies and encourages career ladder opportunities for CNAs by 2004.
▪ Increased penalties for nursing homes with deficiencies (**FL**)	▪ AB 1731 (2000) increased fines associated with violations of licensing standards. For violations that cause the death of a patient, fines were raised from a maximum of $25,000 to a maximum of $100,000. For violations that did or could cause serious harm, fines were raised from a maximum of $10,000 to a maximum of $20,000.
▪ Increased training for surveyors (**TX**)	▪ CA has a nationally recognized Surveyor Academy that includes six full-time weeks of didactic instruction interspersed with field experience and mock surveys (three months total). All new surveyors must complete this Academy and attend and pass a 40 hour federal Basic Surveyor Course.
▪ Establish Quality of Long-Term Care Facility Improvement Trust Fund to support quality initiatives (**FL**)	▪ AB 1731 (2000) included provision for quality awards to exemplary facilities. → Innovative grants to nursing facilities to fund projects that demonstrate methods to improve quality of care and quality of life for nursing home residents

TABLE 6.

CALIFORNIA COMPARISON: NURSING HOME LIABILITY INSURANCE REFORMS

Adopted or Introduced in 2001-02 by Other States

(States in bold have enacted statutes)

Other States' Quality Initiatives	Existing California Statute or Process
▪ Require review of survey process (**TX**)	▪ AB 1731 (2000) required a report to the Legislature on the effectiveness of the DHS enforcement system.
▪ Require review and report on the effectiveness of legislative revisions to improve the liability insurance situation (**TX)**	▪ AB 430 (2001) required a report to the Legislature on the cost and availability of liability insurance to long-term care providers.
▪ Designation of specific component of the Medicaid reimbursement rate for liability insurance (**TX)**	▪ During 2000/2001 long-term rate study DHS recognized a rate add-on for certain long-term care providers to reflect an acknowledgement of the increasing cost of liability insurance, DHS is currently analyzing industry requests (and supporting documentation) to increase rates in response to rising liability costs. AB 1075 (2001) mandates that CA adopt a facility-specific rate-setting system by 2004. Details regarding the methodology to be implemented are not yet available.

Source: *Prepared by the Department of Health Services. Includes information from "State Overview: Nursing Home Liability Insurance Reforms" Adopted or Introduced in 2001-02, Senate Office of Research (3/1/02)*

[1] Deborah Hedgecock and Jennifer Salmon, *Lawsuits and Liability Insurance Experience of Florida Nursing Facilities, January-October 5, 2001*, Florida Policy Exchange Center on Aging, University of South Florida, Tampa, FL, December 18, 2001, p. 3.
[2] Theresa Bourdon, and Sharon Dubin, *Florida Long Term Care General Liability and Professional Liability Actuarial Analysis,* AON, January 17, 2000, p 5.
[3] *Overview of the Staff Findings and Recommendations Included in the Informational Report of the Task Force on Availability of Long-Term Care.* Florida Policy Exchange Center on Aging, June 30, 2001, p. 5. www.fpeca.usf.edu.
[4] *Final Staff Informational Report to the Task Force on Availability and Affordability of Long-Term Care in Response to House Bill 1993,* Florida Policy Exchange Center on Aging, University of South Florida, Tampa, FL, January 28, 2001, p 5.
[5] Hedgecock, op.cit , p.1.
[6] Select Committee on Liability Insurance for Long Term Care Facilities, "Executive Summary," of the *Final Report: Select Committee on Liability Insurance for Long Term Care Facilities*, page 1, March 15, 2002.
[7] Ibid., p.2.
[8] "Nursing Home Liability Insurance Rates: Factors Contributing to the Rate Increases in Texas," *Brief*, Senate Research Center, Austin, TX, February 2001, p.5.
[9] "Best Practices Adopted to Curb Nursing Home Claims," Texas Department of Insurance, December 4, 2001. www.tdi.state.tx.us/commish.
[10] "Nursing Home Liability Insurance Rates…," op.cit, p.7.
[11] Stephanie K. Jones, "The Shrinking, Expensive Market for Nursing Home Coverage," *Insurance Journal Property and Casualty Magazine*, August 2001, p. 2.
[12] House Insurance Committee, "Interim Committee Hearing Report", May 6, 2002.
[13] Devore, op.cit., p. 5.
[14] Ibid.
[15] Lawrence J. Beaser, and Howard Burde, "The New Mcare Act-Significant Long Term Reforms; Modest Short-Term Relief," Pennsylvania Osteopathic Medical Association, www.poma.org.
[16] Bourdon, op.cit., p 3.

VII. OPTIONS FOR CONSIDERATION

The following options are provided for discussion. They represent a compilation of alternatives proposed by various stakeholders and are not intended to serve as recommended actions. The list is summarized in Table 7, beginning on page 103. DHS Recommendations can be found in Section VIII, beginning on page 105.

Cost and availability of liability insurance are critical issues for California nursing homes and other residential long-term care facilities experiencing jumps in premiums and difficulties in securing coverage. LTC providers desire immediate solutions that will ensure the business of providing nursing home or residential care is one in which they can successfully operate. Consumer attorney organizations and advocates want to ensure that the solutions being considered will not limit the rights of nursing home residents.

From the perspective of state health policy, any actions taken to improve cost and availability of liability insurance must also consider other related questions:

- *Will Californians have a continuum of quality, LTC options as they age?*
- *Should government facilitate alternative insurance arrangements, using methods that minimize the influence of national trends? Are there other ways to separate or "de-link" California's insurance business from the global insurance market?*
- *Are there business incentives to support quality, financially stable LTC providers?*
- *How should liability insurance costs be considered in the Medicare/Medi-Cal rate methodologies?*
- *What consumer incentives to encourage LTC insurance coverage could reduce government's major funding role?*
- *When a resident suffers elder abuse in a nursing home, what provisions would strengthen the relationship between civil action and state enforcement action to ensure improved quality of care for all residents in that facility?*
- *What steps can California take to minimize financial risk in its dual role of protector residents and "payer of last resort" in the case of failed SNFs?*

1. INSURANCE INDUSTRY

In many ways the insurance industry is the purest form of a free market. Very simply, revenues must cover loses. However, that is the end of the simplicity. The structure and inter-relations of the insurance companies are intricate and complex. The system has consolidated into large multinational conglomerations, in which California's nursing home liability insurance concerns are only a minor piece of the operations.

The insurance market, similar to other industries, is highly cyclical in nature. Change in the competitive environment and available returns from investments can have a significant affect on the market. The market is currently "hardening," and insurance companies are narrowing their product offerings to focus on their core business. They are changing their policy and premium structure to respond to and anticipate the changes in the risk environment. The challenge in addressing options to ensure affordability in nursing home liability insurance lies in de-linking the industry from all the national and international activities beyond the sphere of influence of the California nursing homes.

Insurers, however, are already responding to the changes occurring in the market. While some companies are withdrawing product lines, others are looking for opportunities to move into the market niche. The insurance industry is very resilient. It is difficult to identify where the market is and where it is going. A short-term attempt to support the insurance rates may impede on the market correction being undertaken by the industry or threaten the existing insurance providers, causing their withdrawal from the California market. From an insurance perspective, possible policy options are enhanced information on this segment of the industry's activities; alternative insurance arrangements, and alternative reinsurance arrangements.

A. Annual Industry Report

The professional and general liability insurance market for LTC providers has undergone dramatic change in a short time period. The nursing home industry alerted the regulating agencies as to their concerns. Even with focused attempts to extract information, the data has been limited. Regardless of what decisions may be reached to facilitate the availability and affordability of liability insurance for nursing homes, ongoing monitoring will be necessary to measure any type of success. Regulators must also be watchful of crossover impacts on the assisted living industry.

Following a crisis in liability coverage for childcare providers, the CDI began publishing an annual focused report on the coverage and performance of admitted carriers offering lines of liability coverage for child care providers (Insurance Code Section 1864).

A report similar to that published for the state's childcare providers in the CDI's annual report could be developed for the nursing home and assisted living facilities. Such a report is of additional importance for the nursing home industry that has the predominance of funding tied to public payers. Increasing costs of liability insurance must be absorbed by the organization's operating budget. Significant increases in overhead costs will cause a fiscal strain on operations. The consequences of a facility going bare, without liability insurance, could be financial insolvency of the institution. The state will ultimately intervene in the occurrence of facility bankruptcies or abandonment—bearing unknown costs.

OPTION 1-A: *CDI could provide an annual report on the availability, affordability and insurance performance specific to nursing home and assisted living, general and professional liability insurance.* Mandate insurers engaged in writing nursing home liability insurance coverage are to submit an annual report of its operations in regards to claim experience, policies written and earned premiums.

Advantages

- Increases the amount of information available to the regulating agencies.
- Increases communication among CDI, DHS and DSS.
- Establishes a baseline to determine the affect of other policy actions.
- Provides consistently reported data for monitoring trends.

Disadvantages

- Increases administrative time and cost of compiling the information for reporting purposes.
- Includes only information from admitted insurers.

B. Insurance Rate Rollback

In 1988, a rate rollback was initiated for automobile policies. Every insurer was required to reduce its charges to levels that were at least 20 percent less than the charges for the same coverage in effect in 1987. The rates were only allowed to increase if an insurer could demonstrate a substantial threat of insolvency (Insurance Code Section 1861). Further, the Insurance Code stipulated specific criteria to be used to underwrite an automobile policy.

OPTION 1-B: *CDI produce a report for the Legislature to address whether a mandatory rate rollback for LTC liability insurance would be effective, and recommend underwriting criteria that should be used in determining low risk SNFs.*

Advantages

- Reduces rates for liability insurance.
- Establishes underwriting criteria to reward quality improvements through lower insurance premiums.

Disadvantages

- Deters admitted insurers from operating in California.
- Augments previous rate relief resulting from CDI's denial of requested base rate increases to admitted insurers.
- Potentially increases liability insurance for other industry segments.

C. Facilitate Captives

CDI has very limited ability to quantify what is happening in the marketplace outside of the information reported by the admitted insurers. Less than 6 percent of the licensed SNF beds in California are covered by these types of insurers. The first reaction as the insurance industry starts to experience difficulties, is a shift from admitted insurers to excess and surplus line insurers, which are not regulated by the CDI. CDI is therefore further limited in its ability to analyze or to respond to the condition of the marketplace.

Florida recently mandated **compulsory** liability insurance coverage by admitted carriers only. While the state is still awaiting enough information to determine the outcome, some observers question the likelihood of success.

Another venue for control comes from insurance companies choosing a state as their **domain**. Currently California is not a favored state for licensure by insurance companies or other forms of insurance vehicles. Hawaii and Vermont are two states that have a predominant share of the Risk Retention Group licensure. Texas and Illinois are also favored charters for Purchasing Groups. Other states are actively pursuing efforts to encourage domiciled captives, such as this option envisions.

OPTION 1-C: *CDI could convene a workgroup that will review the Insurance Code to identify changes that may enhance the attractiveness of the State of California for the licensure of insurance captives, Risk Retention Groups, and Purchasing Groups. Report these findings to the Legislature, including the review of other states' requirements and the advantages and disadvantages of such structures.*

Advantages

- Provides additional regulatory authority over insurance options without restricting the insurance market.
- Facilitates alternative forms of insurance, allowing state associations and professional groups to provide for insurance coverage for their members.
- Facilitates insurance options that can allow for underwriting credits to be given based on quality indicators and/or model practice guidelines.

Disadvantage

- Fails to create additional insurance or necessarily affect the market price.
- Requires insurers to continue to go to unregulated reinsurers.

- Potentially makes California a favored domain for out-of-state operations without enhancing coverage in California.
- Increases administrative cost of additional regulatory oversight of insurance operations, though offset exists with the fee structure of the CDI.

D. Joint Underwriting Association (JUA)

The State could establish a JUA to pool LTC liability insurance risk, and structure the underwriting criteria for the policies. The pool could be established through assessments on the participating insurance carriers, or directly funded by the issuance of bonds, or a combination of both funding mechanisms. With the current claims trends, reinsurance would need to be secured to limit the exposure of the pool and a limit on payout from the pool would be necessary. The State is now exposed to the cost of SNF bankruptcies if costs that might default to the State go beyond what is available in the State Citation Penalty Account. The financing of an insurance pool therefore may serve as a prudent expenditure.

After the Northridge earthquake in 1994, residential insurers grew concerned that another earthquake would exhaust their resources; in response, the California Legislature established the California Earthquake Authority (CEA). The CEA is a privately financed, publicly managed organization that offers basic earthquake insurance for California homeowners. State general fund moneys are not used in the pool reserves and are not at risk if the full amount of the reserves is expended. The creation of the CEA allowed the insurance companies to cede liability for the earthquake portion of the homeowner policies (Insurance Code Section 10089.5).

OPTION 1-D: *Authorize CDI to establish a JUA to manage professional and general liability insurance.*

<u>Advantages</u>

- Provides a benefit for admitted insurers to remain in the market with other associated products.
- Facilitates insurance options that can allow for underwriting credits to be given based on quality indicators and/or model practice guidelines.

<u>Disadvantages</u>

- Fails to create additional insurance or necessarily affect the market price.
- Requires the State to continue to use the reinsurance market for stop-loss. The State, however, would wield greater ability to negotiate the reinsurance terms.
- Increase administrative cost of additional regulatory oversight of insurance operations. However, the fee structure could include a mechanism to offset administrative costs.

E. Risk Reinsurance Model

One of the consistent factors underlying all insurance options is the reinsurance market, which has undergone tremendous losses in the recent years, including the billions of dollars paid out in association with the September 11th tragedies. The state could adopt a pooling structure to establish reinsurance for long-term care liability insurance.

OPTION 1-E: *The CDI to convene a workgroup to evaluate the precedence of a state reinsurance pool, potential pool structure, funding, and model the risk exposure and options to mitigate the exposure.*

Advantages

- Provides a benefit for insurers to stay in the market and for captive and pooled insurance arrangements to be established.
- Encourages insurance options that allow for underwriting credits to be given based on quality indicators and/or model practice guidelines.

Disadvantages

- Fails to create additional insurance or necessarily impact the market price.
- Increases administrative cost of additional regulatory oversight of insurance operations, though offset exists with the fee structure of the pool.

2. QUALITY OF CARE OVERSIGHT AND REIMBURSEMENT

In a recent national survey conducted by The NewsHour with Jim Lehrer, responses indicated that "Americans see an important role for nursing homes in providing care for those not able to care for themselves, yet they also voice significant concerns about the care provided in nursing homes."[1]

The continued concerns expressed by federal and state legislators, and the constant negative portrayal of nursing home care in the media, demonstrate that overall quality must be improved. The public must perceive nursing homes as part of an acceptable LTC continuum to ensure the continued availability of care options.

Almost 15 years ago, the federal government established a framework to ensure the provision of quality services to nursing home residents whose care is paid for by the Medicare and Medicaid programs. Today, CMS continues to take additional steps to emphasize quality of care, outcome measurement, and empowerment of consumers through provision of detailed information from which to evaluate nursing home care.

The Davis Administration quickly perceived that to improve LTC in California, quality needed to be defined in broader terms. He recognized the direct relationship between quality of care and the financial stability of the facility where

care is being provided. Aging with Dignity, through legislation, the budget, and administrative actions, already has made significant stride to coordinate and strengthen the State's systems that oversee that oversee the provision of LTC services.

The nature of the insurance industry is to gain predictability and consistency. By further integrating performance and quality improvement into its nursing home oversight systems, government will be providing consumers and insurers information useful to evaluating positive performance of nursing homes in the area of quality and staffing.

A. Risk Management Plans

Risk management and loss control programs, quality assessment and assurance programs, and compliance programs, are all methods a nursing home may use to assess and correct systemic issues and problems that increase risk of a lawsuit or enforcement actions. The federal OIG believes that:

> "a comprehensive compliance program provides a mechanism that brings the public and private sectors together to reach mutual goals of reducing fraud and abuse, enhancing operational functions, improving the quality of health care services and decreasing the cost of health care."[2]

California currently has no requirements that a nursing home establish a risk management program. A SNF must have a patient care policy committee, an ongoing staff development program, and must have a committee to meet quarterly to identify issues applicable to quality assurance, and implement appropriate plans of action for identified quality deficiencies.

This focus on quality improvement is similar to a focus on risk reduction in that both address the same situation, but from two different perspectives. Insurance companies would like to be confident that nursing homes are also monitoring their internal activities from the risk management perspective, correcting practices that are known to have a high litigation risk.

OPTION 2-A: *Encourage or require nursing homes to develop and utilize a risk management program that contains specific predefined elements. Establish incentives related to quality recognition, liability insurance pool eligibility or rate considerations for facilities that operate an approved type of risk management program.*

Advantages

- Supports nursing home efforts to improve internal review and improvement mechanisms.

- Allows insurance companies to use information as a tool to assess effectiveness of a facility's internal risk management systems when determining whether to write a policy.

Disadvantages
- Requires increased facility costs/staff to develop and implement system.
- Requires increased DHS staff to develop and implement a review/approval process.
- Fails to directly affect the availability or market price for liability insurance.

B. Nursing Home Liability Insurance Data from Existing Sources

Basic data on liability insurance coverage in nursing homes would improve DHS' ability to assess changes in the market, and to monitor for financial stability. At the present time, DHS does not attempt to determine the status of liability insurance coverage for the nursing homes it licenses; however, DHS does have access to liability insurance information for facilities participating in the Medicaid program.

Facilities participating in the Medi-Cal program are required to report financial and utilization data annually on the Long-term Care Facility Integrated Disclosure and Medi-Cal Cost Report.[3] While costs for liability insurance premiums are not specifically identified on the form, they are included in the Administration cost center on the form.

The reports filed by nursing homes consist of financial statements and supporting revenue and expense schedules, utilization statistics, and other facility information. When the reports are submitted by facilities, they are entered into the OSHPD database and are desk-audited. DHS uses OSHPD data in the development of its nursing home rates. DHS, A&I Branch, audits some portion of nursing homes participating in Medi-Cal each year. Staff review all aspects of a facility's financial reports at that time, including liability insurance premium payments and other cost information related to litigation.

According to the CDI data call conducted in 2000 (see Section II, page 11), only 185 nursing homes had liability insurance coverage from admitted insurers. CDI has the capability to continue to conduct such data calls to determine liability insurance trends among admitted insurers, but few nursing homes appear to be covered by admitted insurers. Unless significant changes occurred in the insurance market, future data calls would continue to provide information for only a limited segment of California's LTC providers.

Aon Risk Consultants, Inc, in its February 2002 actuarial analysis of "Long Term Care General Liability and Professional Liability," based its California information on voluntarily submitted data from SNFs representing 22 percent of beds in the State[4] (see Section II, page 14). Without a higher level of voluntary participation from SNFs in California, trend information could be misleading. For example,

CMS data about the 10 nursing home companies with the largest bed counts indicate that they own 18.46 percent of beds nationwide. If a significant number of the 22 percent of beds voluntarily reported consisted of beds owned by these 10 companies, the data might not provide an accurate picture of liability insurance costs and availability for all nursing home providers in the state.

DHS can conduct a survey of California nursing homes, requesting them to voluntarily submit information regarding their policy structure and the liability insurance options they are utilizing. If the facility response rate to the survey is high, the information could be useful in developing a current picture of nursing home experience with liability insurance.

OPTION 2-B: Utilize existing sources of information more effectively to identify trends in the cost and availability of liability insurance for nursing homes. These would include:

- *CDI information from admitted insurers;*
- *OSHPD information from the Long-term Care Facility Integrated Disclosure and Medi-Cal Cost Report;*
- *DHS information from the MCS, Rate Development Branch and from the A&I audits of nursing facilities that participate in the Medi-Cal program; and*
- *A voluntary survey of nursing homes.*

Advantages

- Provides data to utilize for developing policy decisions related to liability insurance.
- Secures data from existing sources, and would not require legislation.

Disadvantages

- Fails to provide comprehensive and consistent data to utilize for developing policy decisions related to liability insurance.

C. Nursing Home Liability Insurance Data as a Condition of Licensure

As discussed in Option 2-B, nursing home liability insurance coverage data would improve the DHS ability to assess the affect of changes in the insurance market. For an option that would require a statutory change, DHS could mandate that nursing homes licensed in California provide specific information on liability insurance coverage as part of the application process. The facility also would notify DHS whenever changes occurred in the policy.

While such a system provides consistent and comprehensive information that can be used for developing policy decisions related to liability insurance, it also requires sufficient DHS staff to collect, evaluate, and manage the data submitted.

From a provider perspective, liability insurance premium and coverage data collected by DHS would be subject to Freedom of Information Act requirements. In Florida, every SNF now must purchase liability insurance. A recent provider

industry publication cites an insurer that anticipates the statute will result in SNFs "purchasing compliance policies—plans that offer little coverage but that ensure compliance with state laws."[5] To protect liability insurance data from public disclosure, SNFs may approach a liability insurance data mandate in the same manner.

Option 2-C: Require nursing homes to provide DHS basic information on liability insurance coverage, at the time of application and annually thereafter (including an update if circumstances change during the year).

Advantages
- Provides comprehensive data to utilize for developing policy decisions related to liability insurance.

Disadvantages
- Fails to provide DHS authority for any action other than compilation of data.
- Fails to affect the availability or market price for liability insurance.
- May discourage SNFs from securing adequate liability insurance coverage.
- Increases DHS administrative time and cost of compiling the information for reporting purposes.

D. Skilled Nursing Facility Financial Solvency Advisory Board (SNFFSAB)
AB 1731 established the SNFFSAB, part of the Governor's Aging with Dignity Initiative. The Board will consist of a panel of experts to advise DHS of appropriate financial standards for facilities and methods to monitor facility financial standards. Information gathered for this report has identified that the availability and cost of liability insurance for a facility can affect quality of care and financial solvency.

OPTION 2-D: *Ensure the SNFFSAB includes a representative with expertise related to the insurance industry. Require the Board to advise the DHS director as to the implications for financial solvency standards of the data on liability insurance rates.*

Advantages
- Ensures a member with insurance industry expertise is involved in developing fiscal solvency requirements for facilities.

Disadvantages
- Fails to directly affect cost and availability of liability insurance for nursing homes.

E. Nursing Home Liability Insurance Coverage as a Condition of Licensure
If a nursing home cannot secure liability insurance or cannot afford the premium, and decides to carry no liability insurance at all, the financial stability of the facility is at a much greater risk. Colorado, Utah, and Pennsylvania already have

a requirement for liability insurance coverage. Florida and Texas recently passed legislation that requires liability insurance as a condition of licensure. In both states, provider concerns already have been expressed regarding the effectiveness of the requirement (see Section VI, What Happened in Florida, page 70; and Section VI, What Happened in Texas, page 72).

OPTION 2-E: *Require nursing homes to demonstrate proof of liability insurance coverage as a condition of licensure.*

Advantages
- Reduces risk that a nursing home would go bankrupt because of insufficient funds to cover a lawsuit settlement or judgement.
- Provides comprehensive data to utilize for future policy decisions related to liability insurance.

Disadvantages
- Requires staff to develop and implement policies and procedures to determine compliance with the requirement. Also requires staff to monitor and review data.
- Could result in closure of nursing homes unable to secure coverage.
- May discourage SNFs from securing adequate liability insurance coverage.
- Fails to necessarily affect the availability or market price for liability insurance.

F. Establish Incentives Related to Liability Insurance to Support Nursing Homes Improvements to Quality of Care.

Nursing homes play an essential role in California's LTC system. Published articles and discussions with representatives of the insurance industry and the health care provider industry confirm providers are experiencing increases in premiums for liability insurance.

If the State can assist nursing homes that meet specific quality-related criteria to secure liability insurance coverage, that assistance might ensure consumers continued access to adequate, high quality LTC facility options. Such support could be provided using a variety of methods, including monetary subsidies.

The quality criteria could be similar to the criteria for AB 1731 quality awards facilities, or could utilize CMS data similar to the pilot being implemented in Colorado, Maryland, Ohio, Rhode Island, and Washington (see Section III, page 32). The criteria could be based on an agreement model, similar to the OIG Corporate Integrity Agreements (see Section IV, page 56). To receive assistance with liability insurance, the facility might agree to a risk management program or to an enhanced level of staffing. The assistance might take the form of eligibility for coverage through a state JUA (should such an option be adopted). Assistance also might be included under a facility-specific rate.

Another example illustrating the type of creative support that could be fashioned to assist the long-term care facilities is the model of the California Partnership for Long-term Care. The Partnership's LTC policy offers incentives to individuals to secure LTC coverage, in cooperation with a select number of private insurance companies. These companies offer high quality policies that must meet stringent requirements set by the Partnership and the State of California. When the policyholder needs care, the policy pays for the care, but for each dollar the policy pays out in benefits, it entitles the policyholder to keep a dollar of assets should she or he ever need to apply for Medi-Cal benefits. A similar creative public-private partnership may be an option for designing rewards or subsidies for exemplary facilities to assist them in purchasing liability insurance.

OPTION 2-F: *Develop programs for nursing homes that can meet quality related criteria to assist in securing adequate liability insurance coverage.*

Advantages
- Supports access to an adequate, quality, continuum-of-care.
- Supports and encourages exemplary facilities through incentives to provide quality of care improvements.

Disadvantages
- Requires staff to develop and implement procedures and negotiate and manage agreements with facilities.
- Fails to directly affect the availability or market price for liability insurance.
- May require general fund expenditures to implement.

3. CIVIL LAW

The Medical Injury Compensation Reform Act (MICRA) of 1975 and the Elder Abuse & Dependent Adult Civil Protection Act (EDACPA) of 1991 form a strong foundation of civil law in California. Both acts recognize the importance of health and safety considerations, and the right of individuals, especially the elderly and dependent, to protection from abuse and neglect.

MICRA prescribed parameters for civil actions at a time when the Legislature determined that escalating malpractice insurance costs threatened access to medical treatment for California citizens. EDACPA provided enhanced remedies for elderly victims of abuse when the Legislature determined that without such special provisions, deserving individuals were systematically being denied cause of action.

Unlike states such as Florida prior to 2001, the terminology and burden of proof requirements for civil liability and elder abuse cases in California statute are quite specific. Neither provider organizations nor consumer advocates are arguing that provisions for MICRA or EDACPA should be eliminated. The debate surrounds three issues:

- Is access to long-term institutional health care for Californians being threatened due to the impact of lawsuits filed under EDACPA?
- Are modifications possible to the enhanced remedies under EDACPA that would continue to provide protections to victims, but would also encourage insurers regarding the stability and level of risk associated with the long-term industry as a whole?
- When a resident suffers elder abuse in a nursing home, what provisions would strengthen the relationship between civil action and State enforcement action to ensure improved quality of care for all residents in that facility?

A. Enhanced Information on Lawsuits, Settlements, and Awards in California

DHS does not have sufficient data on civil actions against nursing homes to demonstrate whether current MICRA and EDACPA provisions threaten Californians' access to LTC options. While H&S Code 1305 does include language that requires liability insurers to report to DHS on specific nursing home claims and settlement information, that 30 year requirement was never implemented. Data has been gathered by a variety of organizations but the information currently available on the impact of lawsuits, settlements, and awards is mainly anecdotal. Examples include:

- Information is available from an individual California insurer that the number of claims in California is not growing dramatically, but the severity, or cost of individual claims, is significantly above the average for other states. The experience of this insurer, however, was limited to less than 13 percent of California nursing homes.
- The February 28, 2002, Aon report on liability insurance confirmed that growth in numbers of claims was not substantial in California, but the increase in cost was more significant. The information provided by nursing homes to Aon was voluntarily submitted by only 22 percent of California facilities.
- VerdictSearch is the research service of the National Law Journal's litigation services network. In January 2002, Consumer Attorneys of California, a professional association for attorneys who represent plaintiffs/consumers, requested that VerdictSearch research elder abuse or nursing home negligence cases where awards were made for the period 1995 to present. While some settlement information was also provided, this information had been voluntarily submitted. In many cases, the information was designated confidential, so it was unclear which nursing home had been affected.
- GeneralCologne Re conducted a study of 58 voluntarily reported verdicts and settlements for long-term care providers and concluded that claims costs are escalating and that multimillion dollar verdicts and settlements have replaced the more moderate payments previously associated with personal injuries awards to individuals with a short life expectancy and minimal wage loss.

In the last two years, a number of states have begun instituting changes to increase available information regarding court decisions relevant to public health and safety:

- Florida legislation aimed at improving the liability insurance situation for LTC providers included a provision to require facilities to report monthly any liability claim filed against it. The report must include the name of the resident, the date or dates of the incident leading to the claim, if applicable, and the type of injury or violation of rights alleged to have occurred. This report is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in such actions brought by the enforcement agency.[6]
- In September, 2002, "South Carolina's 10 active federal trial judges unanimously voted to ban secret legal settlements, saying such agreements have made the courts complicit in hiding the truth about hazardous products, inept doctors and sexually abusive priests."[7] If the court formally adopts the rule after a public comment period that ends September 30, 2002, it will be the strictest ban on secrecy in settlements in the federal courts.
- On October 1, 2002, Governor Davis signed SB 1572 (Sher), that requires private persons settling any violation of the Safe Drinking Water and Toxic Enforcement Act of 1986 (Proposition 65) to report to the AG, regarding the settlement and the final disposition of the case. The AG may provide factual information to specified attorneys involved in related cases, "but in all other respects the Attorney General shall maintain, and ensure that all recipients maintain, the submitted information as confidential official information to the full extent authorized in Section 1040 of the Evidence Code."[8]
- In September 2002, the Governor also signed SB 1950 (Figueroa), that includes provisions to expand the public information available regarding malpractice claims maintained by the Medical Board of California. Existing law requires every professional liability insurer to report to the appropriate medical board any settlement over $30,000 and any judgments or awards in any amount of a malpractice claim or action against a licensee of that board. Prior to this legislation, settlements were not considered public information.
- On October 15, 2002, the Administration announced a consumer protection initiative to protect nursing home residents. One of its provisions required nursing homes to report to DHS all civil court actions filed against them.

OPTION 3-A: *Require every professional liability insurer or every SNF to report to DHS regarding liability claims filed against a facility, and settlements, judgments, and awards against a facility.*

Advantages

- Enables DHS to have baseline data that identifies the frequency and severity of the cases affecting nursing homes in the state for use in policy analysis and review of enforcement actions.

Disadvantages

- Providers may oppose provisions that result in the disclosure of information that may be perceived by the public as damaging to the reputation of the facility.
- May create a disincentive for providers to settle cases, especially when they do not believe they are at fault.

If data demonstrates that access to long-term health care is being threatened by the current provisions of MICRA and EDACPA, the options described below identify several points in these processes where changes could be made.

B. Pre-Suit Requirements

California presently requires the plaintiff to notify the facility of its intent to file a medical liability or elder abuse claim. According to the Code of Civil Procedures, no action based on professional negligence can be filed before giving a 90-day notice.

Of the lawsuits related to elder abuse that reach the media, the victim or family often express a desire for prevention or deterrence as the reason for the lawsuit. Pre-suit action that ensures future compliance or correction of the systemic cause that led to the elder abuse situation could reduce the need for judicial relief in some situations. In California, however, consumer advocates have opposed efforts at forced arbitration, mediation, or dispute resolution in lieu of lawsuits.

OPTION 3-B: *Establish provisions related to arbitration, mediation or DHS regulatory enforcement that must occur during that 90-day period.*

Advantages

- May decrease the number of claims filed against the facility, which could improve insurability of the facility.

Disadvantages

- May place further pressure on the plaintiff to settle when any offer to mediate or arbitrate is made by the defendant.

C. Reduce Statute of limitations

In an action against a health care provider based upon professional negligence, California has a three-year limitation under MICRA (or one year after the plaintiff discovers the situation, whichever comes first). EDACPA carries a one-year limitation during which a plaintiff may file a lawsuit. While this option has been included because other states have considered such limitations in addressing the liability insurance issue, due to current stringent limitations, in California the effectiveness of this option may be limited.

OPTION 3-C: *Shorten the statute of limitation for MICRA to less than three years.*

Advantages
- May provide limited improvement in the ability of the insurer and the provider to predict losses.

Disadvantage
- May decrease the ability of a person to discover a potential cause of action, if such information is not readily apparent.

D. Specify the Method for Determination of "Reasonable Attorney's Fees"

Nursing home provider organizations and insurance industry representatives believe that current provisions that allow attorneys to be reimbursed for their fees in elder abuse cases, leads to inflated costs that are not necessarily commensurate with the outcome for the plaintiff. A more structured definition of "reasonable" could protect the rights of elder abuse victims without encouraging unnecessary litigation that increases liability insurance costs.

Section 15600 (j) of the Welfare and Institutions Code states the intent of the Legislature to enable interested persons to "engage attorneys to take up the cause of abused elderly persons and dependent adults." Prior to passage of EDACPA, few civil cases were brought in connection with elderly abuse due to the lack of incentives to prosecute. MICRA provisions assumed clients in the prime of life, not in their waning days, or even after death. A percentage of compensatory damages for an attorney might not be sufficient to take the case of an elder who could not demonstrate significant lost wages or lost years of life.

OPTION 3-D: *Define "reasonable" attorneys' fees in more specific terms in the EDACPA statute, or establish a necessary relationship between "reasonable attorneys' fees" and the specific case.*

Advantages
- May decrease the number of elder abuse claims filed against facilities that may reduce liability insurance costs.

Disadvantages
- May increase the elder and dependent adults who experience abuse or neglect but are unable to secure civil action.

E. Modifications to Requirements for Punitive Damages

Punitive damages "punish" the defendant for egregious, deliberate, or harmful misconduct. Punitive damages normally are not insurable and are paid directly by the nursing home. A punitive damage claim, however, also increases the overall amount for which an action may be resolved. Nursing home providers argue that the use of punitive damages under provisions of EDACPA treats nursing home defendants differently from other health care providers under other medical malpractice law. They believe this erosion of MICRA directly affects the cost and availability of liability insurance.

Consumer advocate groups believe California nursing home verdicts, including punitive damage awards, encourage decent care and are a vital check to balance the health care system. In Florida's recent legislation to address problems with liability insurance for nursing homes, any award of punitive damages is to be divided between a plaintiff and the state's Long-term Care Facility Improvement Trust Fund.

OPTION 3-E: *Consider one of the following alternatives: 1) Place a cap on punitive damages; 2) Create a scale of "contingency fees" for attorneys based on the amount of the punitive damage award (the higher the judgement, the smaller the percentage to be claimed by the attorney); or 3) Establish provisions that allocate a portion of awards going to attorneys beyond a specific level to fund enforcement and improvements to quality of care in nursing homes.*

Advantages
- May reduce the number of claims filed and/or the size of the awards that may result in reduced liability insurance costs for facilities.

Disadvantages
- May discourage elders and dependent adults who experience abuse or neglect from securing civil action.

F. Criminal Investigation of Cases Awarding Punitive Damages

Punitive damages were created by the courts to punish defendants for egregious conduct and, for the sake of example, to deter others from similar conduct. DHS currently works closely with the Bureau of Medi-Cal Fraud and Elder Abuse within the AG's Office on elder abuse cases. Whenever DHS receives a complaint that alleges abuse, neglect, or misappropriation of resident funds or property, DHS notifies and faxes a copy of the complaint to the Bureau upon receipt. DHS continues to investigate the complaint and provides documentation and assistance should the Bureau decide to prosecute. If cases result in multi-million dollar punitive damage awards, a focused study might be in order to determine the effectiveness of the current regulatory enforcement system in these cases where individuals needed to privately seek judicial relief.

OPTION 3-F: *DHS, in consultation with the Bureau of Medi-Cal Fraud and Elder Abuse, will carefully review and report on a sample of cases known to have resulted in high punitive damage awards. A multi-disciplinary team will analyze the relationships between enforcement actions and the court cases against the facilities.*

Advantages
- Provides DHS with further baseline data to identify the frequency and severity of the cases affecting nursing homes.

Disadvantages
- Requires staff or contractor to conduct research and analysis of available information.

G. Limits on Admissibility of Licensing Inspections and Citations as Evidence

L&C conducts on-site inspections of licensed health facilities on a periodic basis, and in response to complaints filed by the public. At the completion of the inspection, surveyors prepare a report to the facility listing violations of various laws and regulations. The facility is then required to prepare a POC. After DHS accepts the POC, a follow-up visit can be scheduled to ensure that all needed corrective actions have been taken. The policy behind this process is straightforward—when problems are found in health facilities, those problems should be corrected as soon as possible.

L&C's inspection findings can be, and are currently used in civil litigation, particularly with respect to nursing homes. Neither the act of providing a POC, however, nor its contents or implementation, may be used in any legal proceeding as an admission by the facility that the violation leading to the POC occurred. This is consistent with Evidence Code provisions that evidence of remedial conduct cannot be used to prove negligence or culpable conduct related to the event that caused the remedial action to be taken. The policy premise is to promote timely and appropriate remedial action. Current law does not absolutely prohibit admission of a POC into evidence, but the courts allow it only within the context of the Evidence Code.

OPTION 3-G: *Limit admissibility of state and federal enforcement documents as evidence in a civil action, except when they directly relate to the facts of the case.*

Advantages
- For providers, ensures the information is used for its intended purpose, remedial action to bring about compliance with the Medicare and Medi-Cal programs.

Disadvantages
- For consumer advocates, litigants would be denied a valuable tool for establishing a pattern and practice of poor care. Without this information, any abuse or neglect case can look like an isolated incident.

4. CONSUMER ACCESS TO QUALITY LONG-TERM CARE

The aging population is growing. In federal testimony by William Scanlon, Director of Health Care Issues, at a March, 2001, hearing of the U.S. Senate Committee on Finance:

> Providing and financing long-term care will become even more challenging in just over a decade when the 76 million baby boomers begin to turn 65. Over the next 30 years, the number of elderly individuals is expected to double. Moreover, with baby boomers expected to live longer and greater numbers reaching age 85 and older, this generation is expected to have a dramatic effect on the number of people needing long-term care services, as the prevalence of disabilities and dependencies increases with age.[9]

According to a recent brief published for a congressional health policy conference, "while future demand for long-term care services may exceed supply, providers have difficulty meeting even current need."[10] Nursing homes are one of a number of care options necessary to serve this increasing elderly population, yet data indicate their numbers are going down.

In the CMS ***Nursing Home Data Compendium 2000,*** the number of nursing homes certified to participate in the Medicare and/or Medicaid programs has decreased from 17,253 (in 1997) to 16,847 (in 2000). Nursing home occupancy rates have been decreasing since 1996. In 1996, the occupancy rate was about 85 percent, and in 2000, the occupancy rate was about 82 percent.[11]

Nine million Californians will be over the age of 60 by 2020. What continuum of care will be in place two decades from now? Will there be sufficient caregivers to support the available options? What information will assist Californians in their health decisions? Liability insurance for long-term care providers is only one of the myriad of issues affecting the state's long-term care system.

Health care in the United States is a business enterprise, and consideration must be given to the need for balancing the viability of the business and the implications this has on access to care. At the same time, quality equates to good business. DHS and all the LTC stakeholders concur that providing quality care to the elderly is the number one concern.

A. Access to a Continuum of Quality Care Options

The focus of this report has been cost and availability of liability insurance for LTC providers. While the majority of the literature on the subject relates to nursing homes, escalating liability insurance costs and difficulties in securing coverage play a significant role in the financial picture for all types of senior housing. Governor Davis signed legislation in 1999 to establish a Long-Term Care Council (LTCC). One of its main objectives was to create a framework to address issues collaboratively across state departments that affect quality and access to long-term care.

OPTION 4-A: *After reviewing the report on Liability Insurance for California Long-Term Care Providers, LTCC will determine the appropriateness of the recommendations to other LTC provider types. The Council will also assess what further steps they will implement regarding the liability insurance issue to ensure*

a quality, continuum of care, and services will remain in place for the state's future dependent and elderly.

Advantages
- Ensures that further study of the problems with cost and availability of liability insurance will be conducted to determine their full effect on access to all aspects of the LTC continuum.

Disadvantages
- Fails to affect the availability or market price for liability insurance.

B. Long Term Care Insurance Tax Credit

CMS, in a recent market update report, found that the per diem rates a nursing home receives steadily decline as a resident moves along each step from Medicare to private pay to Medicaid. The Medicare rate of growth has dropped significantly for nursing homes since the Balanced Budget Act of 1997; and Medi-Cal pays for the majority of nursing home costs in California.

Long-term care insurance is the only factor likely to reduce reliance on Medi-Cal as the primary financial resource for nursing home care.

Option 4-B: *Introduce legislation that would provide a state tax credit for the premiums consumers pay to maintain long-term care health insurance.*

Advantages
- Encourages consumers to secure long-term care health insurance.
- Potentially reduces government's role of primary payer for nursing home care.

Disadvantages
- Reduces State revenues.
- Fails to affect the availability or market price for liability insurance.

[1] The Health Unit, op.cit.
[2] "Publication of the OIG Compliance Program Guidance for Nursing Facilities," in *Federal Register,* (Vol. 65, No.52), March 16, 2000, p. 14289.
[3] *Aggregate Long-Term Care Facility Financial Data for California Report Period Ending December 31, 1997-December 30, 1998,* OSHPD, p.xi.
[4] Bourdon, op.cit.
[5] Jeff Smokler, "Florida Legislature Addresses Liability Insurance Crisis," in *Provider,* American Health Care Association, July 2002, p. 10.
[6] 2001, Internal risk management and quality assurance program, Florida Statutes. Section 400.147.
[7] Adam Liptak, "South Carolina Judges Seek to Ban Secret Settlements," in *New York Times,* September 2, 2002.
[8] Health and Safety Code, Section 25249.7(i).
[9] William Scanlon, *Long-Term Care Baby Boom Generation Increases Challenge of Financing Needed Services,* U.S. General Accounting Office (GAO-01-563T), March 27, 2001, p.1.
[10] Cubanski, op. cit.
[11] *Nursing Home Data Compendium 2000,* Centers for Medicare and Medicaid Services, p.1.

TABLE 7.

ALTERNATIVE OPTIONS IMPACT

Alternative Options Impact	Quality Improvement	Elder Abuse Protections	Funding Streams	Facility Financial Stability	Insurance Market Stability	Long Term Care Continuum
1. Insurance						
A. Annual Industry Report				**YES-**Data		
B. Insurance Rate Rollback				**YES-**Lower rates	**NO-**Insurers may leave CA	**YES-**Help other LTC
C. Facilitate Captives	**YES-**If tied to quality indicator			**YES-**Increase options	**YES-**Improve CA as domain	**YES-** Help other LTC
D. Joint Underwriting Association (JUA)				**YES-**Increase options	**YES-**Incentive to stay in CA	
E. Risk Reinsurance Model				**YES-**Increase options	**YES-**Incentive to stay in CA	
2. Quality Oversight and Reimbursement						
A. Risk Management Plans	**YES-**Internal oversight		Increase SNF costs	**YES-**Internal oversight	**YES-**May help get coverage	
B. SNFs Report Liability Insurance				**YES-**Data		
C. SNFFSB				**YES-** Insurance industry perspective		
D. SNFs Maintain Liability Insurance	**YES-**Less risk		Increase SNF costs	**YES-**Less risk		**NO-**May be less SNFs
E. Incentives- Liability Insurance and Quality of Care	**YES-**If tied to quality		Increase M-C costs	**YES-**Increase options for some		**NO-**May be less SNFs

ALTERNATIVE OPTIONS IMPACT

Alternative Options Impact	Quality Improvement	Elder Abuse Protections	Funding Streams	Facility Financial Stability	Insurance Market Stability	Long Term Care Continuum
3. Civil Law						
A. Report Lawsuit/Settlement/Award Data	**YES-**Data tied to quality	**YES-**Data tied to quality		**YES-**Data for baseline		
Modify EDACPA Processes *A. Pre-Suit Requirements* *B. Reduce Statute of Limitations* *C. Define Reasonable Attorneys Fees*		**NO-**May reduce elder access to file suit. (for A,B,C)		**YES-** May reduce claims	**YES-**Insurers indicate would reduce risk	**YES-**LTC providers indicate it would reduce risk
D. Punitive Damages Cap and Funding Enforcement	**YES-**some $ tied to quality	**YES-**tied to deterrence				
E. Criminal Investigation of Punitive Damages	**YES-**If effective deterrence	**YES-**tied to deterrence				
F. Admissibility of Enforcement Documents as Evidence		**NO-**Need to establish pattern		**YES-**May reduce claims		
4. Consumer Access						
A. Long Term Care Council Workgroup						**YES-**affects all LTC
B. Long Term Care Insurance Tax Credit			Increase the % of LTC insurance payments.	**YES-**Increase the % of LTC insurance payments.		

VIII. RECOMMENDATIONS

The LTC industry has grown increasingly concerned with problems related to the availability and cost of liability insurance. Over 20 percent of the individual states have introduced or recently enacted legislation that attempts to address the issue.

Market changes affecting the insurance industry are difficult to predict and even more difficult to influence. The data available to DHS and CDI are limited and generate more questions than they provide answers. However, the insurance industry is reacting to disturbing trends in the LTC arena. Insurers are concerned about quality of care issues in nursing homes. As they evaluate the effectiveness of government oversight, and of the frequency of legal actions, insurers see a greater degree of risk in today's market for writing liability insurance for LTC providers.

Ensuring quality of care has always been the objective of responsible government agencies. In California, under Governor Davis, the focus on nursing homes seeks to consider performance and quality improvement in both its regulatory oversight and Medi-Cal reimbursement systems.

Protecting the civil rights of the abused infirm and elderly should be closely related to enforcement actions to improve quality of care for all residents. However, DHS currently has no system to assess the effectiveness of civil actions to improve quality is not possible.

Promoting a continuum of quality LTC options for California's elderly is a major principle of the Governor's Aging with Dignity Initiative. Provision of health care, however, is a consumer service and a business enterprise. Recommendations must consider quality outcomes, access to care, and impact on business operations.

RECOMMENDATIONS

1. Increase DHS data regarding litigation and insurance claims against nursing homes.
2. Increase DHS data regarding cost and availability of liability insurance.
3. Require nursing homes to implement an approved risk management plan as a condition of health facility licensure.
4. Conduct a study to assure the relationship between enforcement and legal actions in recent elder abuse cases.
5. DHS to work with the LTC Council to evaluate the broader implication of the affect of liability insurance issues on all LTC providers.

DHS recommendations focus on securing the information necessary for rational decision-making, and on supporting facility efforts to improve quality by strengthening facility system(s) to reduce losses.

Recommendation 1.

DHS, in consultation with CDI, the Medical Board of California, and OSHPD, will implement a system, effective January 2004, to notify all nursing homes, ICF-DD facilities, and liability insurance carriers, of the reporting requirements specified in H&S Code, Section 1305 (see Inset).

Section 1305. Insurers; report of judgments and settlements

(a) Every insurer providing professional liability insurance to a health facility licensed pursuant to this chapter and every health facility or associated group of health facilities licensed pursuant to this chapter under common ownership which are self insured shall report periodically, but in no event less than once each year, to the state department any final judgment over three thousand dollars ($3,000) rendered against such health facility during the preceding year of, a claim or action for damages for personal injuries caused by an error, omission, or negligence in the performance of its professional services, or by the performance of its professional services without consent.

(b) In the event that there are no final judgments or settlements in excess of three thousand dollars ($3,000) during the year such fact shall also be reported to the department. (Added by St. 1973).

Implementation of this statute will provide useful data regarding final judgments or settlements over $3,000 rendered against a health facility and specified claims or actions for damages.

In addition, in October 2002, the Administration announced a consumer protection initiative to aid nursing home residents. One of its provisions required nursing homes to report all civil and criminal court actions filed against the facility to DHS.

Recommendation 2.

DHS, in consultation with CDI and OSHPD, will determine by December 2003, the need for a regulatory or statutory change to mandate that nursing homes provide specific basic information liability insurance coverage, at the time of application and annually thereafter. The evaluation will utilize:

- CDI information secured from licensed or admitted insurers in the State;
- OSHPD information secured under current financial reporting requirements for nursing homes;
- Information generated from a survey conducted by DHS, to be issued late 2003, of all nursing home owners regarding their current method of coverage and policy structure, including premiums, deductibles and policy terms.

Recommendation 3
DHS will explore regulatory or statutory changes to require nursing homes to develop and implement a risk management plan that is approved by DHS as a condition of licensure. The requirements will identify the basic component that a facility's plan must include to comply. In general terms, the risk management requirement is summarized below:

Structure
- Risk manager (full-time for a facility of 50 beds or more).
- Risk management committee with ongoing delegated authority to specific individuals for the day-to-day operation of a loss control program.
- Internal processes to provide organizational integrity and corporate compliance with all local, state, and federal laws and regulations.
- Training program for new employees and ongoing coordination of in-service training.

Basic Components
- Regularly planned risk assessments to identify areas of risk in the facility.
- Risk management committee will develop the risk management plan. The risk information must be translated into decisions and mitigating actions.
- A plan for implementing corrective action, including establishing an early reporting and coordinated response procedure.
- A plan for tracking and evaluating the effectiveness and overall performance of the program.
- A program audit that includes a written plan to monitor and test safety and risk avoidance programs.
- A communication system that establishes a process for submitting suggestions or concerns to the risk manager or the risk management committee. A safety and risk avoidance manual describing the organization's structure and approach for maintaining a safe environment to be provided to staff, volunteer personnel, residents and family members.

Documentation
- Action plan and specific priorities for focused efforts of risk mitigation.
- Corporate compliance plan.
- Claims summary and trend analysis—trending should include evaluation of both claims frequency and severity.
- Required document checklist.

- Risk management committee minutes of meetings.

Required Reporting to DHS

- Risk management plan.
- Quarterly generated claims summary, with the organization's trend analysis. Starting in 2006, DHS will publish industry benchmarks for risk management, identify industry trends in claims experience, with mean values as well as one and two standard deviations.

DHS Technical Assistance

- To act as a resource to facilities requesting additional assistance with establishing their risk management programs, or in addressing risk mitigation in any one of the organization's focus areas.
- To act as a resource to liability insurance providers that have questions regarding the information available about LTC facilities that is generated by the regulatory oversight process.

Recommendation 4.
DHS, in consultation with the Office of the Attorney General, Bureau of Medi-Cal Fraud and Elder Abuse, by January 2004, will complete a review of available elder abuse cases that resulted in settlements or punitive damages. The review will address court documents, DHS enforcement actions, performance indicators, and trend data preceding and following the civil action.

Recommendation 5.
DHS will work with the Long-Term Care Council to evaluate the broader implications stemming from the issues raised in the report, *Liability Insurance for California Long-Term Care Providers, A Report to the Legislature*. DHS also will provide any consultation necessary should the Council determine action on the issue at the agency level is required.

APPENDIX A.

TERMS AND DEFINITIONS

Admitted insurer: An insurance company that is licensed (admitted) to conduct business within a given state. If the insurance company experiences financial distress, the regulatory agency can intervene and provide protection to the insured.

Attachment point: The dollar amount of loss where an insurance policy begins to provide coverage.

Activities for Daily Living (ADL): Basic personal activities that include bathing, eating, dressing, mobility, transferring from bed to chair, and using the toilet.

Aging with Dignity Initiative: Governor Davis implemented this Initiative as a policy base for improving long-term care in California. To date, the Administration has committed over $270 million to help elderly people remain at home, or with their families, rather than in nursing homes; dramatically increasing the availability of innovative community-based alternatives to nursing home care; and enhancing the quality of care in California's nursing homes.

Aggregate loss ratio: The total earned premiums for a line of insurance divided by the total claims incurred.

Broker: A marketing specialist who represents buyers of property and liability insurance and who deals with either agents or companies in arranging for the coverage required by the customer.

California Partnership for Long-Term Care: An innovative program of the State of California, DHS, in cooperation with a select number of private insurance companies. These companies have agreed to offer high quality policies that must meet stringent requirements set by the Partnership. The objective is to provide Californians affordable, high quality long-term care insurance that will protect policyholders from having to spend down personal assets, should private long-term benefits be exhausted and Medi-Cal assistance is needed.

Captive insurance company: A company owned solely or in large part by one or more non-insurance entities for the primary purpose of providing insurance coverage to the owner or owners.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services. CMS operates the Medicare and Medicaid programs and maintains oversight of the survey and certification of nursing homes and continuing care providers (including home health agencies, intermediate care facilities for the mentally retarded and

hospitals). Prior to 2001 CMS was known at the Health Care Financing Administration (HCFA).

Certified: To receive reimbursement for the care provided to Medi-Cal or Medicare patients, health facilities must gain federal certification. Certification requirements are defined by federal law, regulation, and policy, and occasionally by state law, regulation, or policy, when the federal requirement is that the state requirement be met.

Certified Nursing Assistant (CNA): In California, to gain certification as a nursing assistant, an applicant must complete 160 hours of training, and pass a competency test and background clearance. Under the supervision of a licensed nurse (registered or vocational), a CNA provides basic nursing services to ensure the safety, comfort, personal hygiene, and protection of patients/residents in a licensed long-term or intermediate health care facility. CNAs may not perform any nursing services that require a professional nursing license. CNAs are sometimes referred to as “nursing assistants” or “nurse aides.”

Cession: Amount of the insurance ceded to a reinsurer by the original insuring company in a reinsurance operation.

Change of Ownership (CHOW): A transfer of control of the physical facility and of the legal and financial responsibility to provide care to patients residing in the facility. DHS L&C approval of the new owner’s licensure application is required prior to completing a CHOW transaction (i.e., prior to closing escrow or executing a lease or rental contract).

Citation (State): A monetary penalty that DHS L&C may assess against a nursing home (or other long-term health care facility) when a facility is found to be out of compliance with state licensing requirements. The penalties range from $25,000-$100,000 for violations that are deemed to be the direct cause of death, to $100-$1,000 for violations that have a direct or immediate relationship to the health, safety, or security of the resident. Other state licensing sanctions include: license revocation; temporary suspension of a license (TSO); temporary manager; and receivership.

Civil action: Any action between private parties that is not a crime or a misdemeanor.

Civil Monetary Penalty (CMP)(Federal): A monetary penalty that CMS may impose against a nursing home (or other long-term health care facility) when a facility is found to be out of compliance with federal certification requirements. CMPs can be imposed not only for every day of non-compliance starting with the days of observation during a current survey, but also for every day of past non-compliance, if that past non-compliance can be ascertained. CMPs are only one of the available federal remedies in the certification survey process. Others include: directed plan of correction (POC); directed in-service training; denial of

payments for new admissions; denial of payments for all residents; state monitoring; temporary manager; transfer of residents; closure and transfer; and termination.

Claim: A request for payment of a loss, which may come under the terms of an insurance contract.

Claims frequency: The number of claims projected for a given time period.

Claims-made policy: A liability insurance policy under which coverage applies to claims filed during the policy period.

Claims severity: The measure of the seriousness of a loss, measured by the total dollar amount of paid claims.

Compensatory damages: See **Damages**.

Complaint: When a call or letter received by DHS L&C requires an onsite investigation (see also **reported event)**. The Health Facility Evaluator Supervisor determines whether an onsite investigation is required.

Compulsory insurance: Any form of insurance that is required by law.

Damages: the monetary compensation or indemnity that may be recovered by an individual or entity that has suffered loss. Damages also vary according to the type of civil action pursued. The types of damages pertinent to a discussion of liability insurance for nursing homes include:

- **Compensatory-**Compensation for a plaintiff's documented out-of-pocket expenses that result from injury or damage; for example, loss of earning or medical expenses.

- **General-**Compensation paid for harm for which no specific evidence of financial loss is required because such harm—for example, pain and suffering—is presumed to have occurred from the nature of the event.

- **Exemplary-**Compensation over and above property loss when the act is from malice—for example, wrongful acts, aggravated negligence, but not criminal.

- **Punitive-**Amount of money awarded by a court to "punish" the defendant for acts of gross negligence or outrageous conduct, normally intentional, irrespective of the amount of actual or compensatory damages.[1]

Domain: The state or location of legal "residency" or licensure for the purpose of the insurance operations.

Earned Premium: That potion of a policy's premium payment for which the protection of the policy has already been given. For example, an insurance

company is considered to have earned 75 percent of an annual premium after a period of nine months of an annual term has elapsed.

Facility-reported occurrence (also unusual occurrence**):** A reported event generated by the regulatory requirement that a facility self-report to DHS L&C specified situations that have occurred at the facility. These occurrences may or may not be determined by the Health Facilities Evaluator Supervisor to constitute a **complaint.**

Form 2567: The federal form, also known as the Statement of Deficiency Form, that outlines the survey findings. The 2567 is sent to the nursing home. If there are deficiencies, the facility prepares its **Plan of Correction (POC)** to DHS L&C**.** DHS must approve the POC to complete the process. If a facility does not submit an acceptable POC, DHS (and perhaps the federal CMS) takes appropriate enforcement actions.

General liability insurance: Coverage that pertains, for the most part, to claims arising out of the insured's liability for injuries or damage caused by ownership of property, manufacturing operations, contracting operations, sale or distribution of products, and the operation of machinery, as well as professional services.

"Going bare": An informal description of an uninsured organization or a firm without any type of insurance program or plan for an exposure that is normally insurable.

"Hardening" or Hard market: That part of the insurance sales cycle in which competitive pricing is at a minimum as companies charge the premiums necessary to meet their underwriting losses in order to avoid insolvency and boost capacity; usually associated with a sharp decline in capacity.

Innovative Grants Program: A program that is part of the Aging with Dignity Initiative (provisions included in AB 1731). Facilities that apply and are selected receive innovative grant awards to fund projects that demonstrate methods to improve quality of care and quality of life for nursing home residents.

Joint Underwriting Association (JUA): A device used to provide insurance to those who cannot obtain insurance in the voluntary market. Certain companies (called carriers) issue policies at one rate level and handle claims, but the ultimate costs are borne by all companies writing insurance in that state.

Licensee: The person, persons, firm, partnership, association, organization, company, corporation, business trust, political subdivision of the state, or other governmental agency to whom a license has been issued.

Licensed Vocational Nurse (LVN): In California, a licensed vocational nurse (LVN) is one who has been licensed by the California Board of Vocational and

Psychiatric Technicians. LVNs, under the direction of physicians and registered nurses, provide basic bedside care.

Licensing requirements: To operate a health facility in California, it is necessary to obtain the appropriate license. Licensing requirements are defined by state law, regulation, and policy.

Lloyd's of London: Insurance marketplace where brokers, representing clients with insurable risks, deal with Lloyd's underwriters, who in turn represent investors. The investors are grouped together into syndicates that provide capital to insure the risks.

Long tail: Risk that may have claims notified or settled long after the risk, or policy term, has expired. So that the underwriter can close the account for the year, it is often necessary for an underwriter to arrange reinsurance protection to cover claims that may arise after the account has been closed.

Long-term care (LTC): Long-term care is a set of social, personal care, health, mental health, substance abuse treatment, and protective services required over a sustained time period by a person who has lost or never acquired some degree of physical or cognitive capacity, as measured by a functional and cognitive assessment rather than being tied to a specific diagnosis or linked exclusively to age. (See also Table 1).

Loss ratio: A ratio calculated by dividing claims into premiums. It may be calculated in several different ways, using paid premiums or earned premiums, and using paid claims with or without changes in claim reserves and with or without changes in active reserves.

Loss reserve: The amount set up as the estimated cost of a claim.

Loss reserve development: How the latest estimate of an insurance company's claim obligations compares to an earlier projection.

Malpractice insurance: Coverage for a professional practitioner, such as a doctor or a lawyer, against liability claims resulting from alleged malpractice in the performance of professional services.

Medicare: Federally funded health benefit plan for persons who are aged 65 and qualify for Social Security benefits, and for person who receive Social Security benefits based on disability.

Medicare Payment Advisory Commission (MedPAC): A 17 member independent federal body that advises the U.S. Congress on issues affecting the Medicare Program.

Medicaid (Medi-Cal): Federal program to provide medical care for eligible low-income people. California uses the term Medi-Cal for the program in the state.

Medical malpractice: Improper care or treatment by a physician, hospital, or other provider of health care.

Minimum Data Set (MDS): See **Resident Assessment Instrument (RAI)**.

Non-economic Damages: See **Damages**.

Nursing Home Data Compendium 2000: A document prepared by CMS to present data on all residents in Medicare and Medicaid-certified nursing homes in the United States. It is the first comprehensive aggregation of data at the level of the individual.

Occurrence policy: A liability insurance policy that covers claims arising out of occurrences that take place during the policy period, regardless of when the claim is filed.

Office of Inspector General (OIG): The organization within the federal Department of Health and Human Services with primary authority for protecting the Medicare Program and its beneficiaries. In addition to various enforcement initiatives, OIG also utilizes several programs that rely on collaboration, cooperation, and voluntary compliance on the part of the health care industry to fight health care fraud and abuse.

Omnibus Budget Reconciliation Act (OBRA) '87: Federal legislation that radically changed the requirements for nursing homes. The revised approach utilized outcome-based measurement and focused on whether a nursing home was appropriately assessing its residents, planning a course of action to meet their multiple needs, and taking actions that were responsive to residents' wishes, capabilities, and changing status.

Pain and Suffering: See Damages.

Plan of Correction (POC): The document that responds to the findings included on Form 2567. DHS L&C conducts on-site inspections or **surveys** of facilities on a periodic basis and in response to complaints filed by the public. At the completion of the survey, staff prepares a report to the facility that may list violations of various laws and regulation. The facility must then prepare a POC addressing how each deficiency will be corrected. The POC must be approved by DHS L&C to avoid enforcement remedies.

Pooling arrangement: An agreement where a group opts to share losses and expenses among members of the pool, typically with each paying a predetermined ratio.

Professional Liability: Coverage for "errors or omissions" found in the conduct of performing professional services. Also see **Malpractice Insurance**.

Prospective Payment System: Payment rates are established before the care is delivered and costs are incurred. Providers, therefore, have an incentive to avoid unnecessary costs.

Purchasing Groups (PG): An organization that puchases liability insurance on a group basis from an insurance company or a **Risk Retention Group (RRG)** for its members. (Also see Table 3, page 24).

Punitive damages: See **Damages.**

Quality Awards Program: A program that is part of the Aging with Dignity Initiative (provisions included in AB 1731). Awards go to facilities whose performance histories indicate that they provide exemplary care to residents. Facilities serving a high proportion of Medicaid residents qualify for financial awards. The statute authorizing these quality awards requires that any monetary awards be distributed as bonuses to staff of the facility.

Qui-Tam*:* ("who sues on behalf of the king as well as for himself") A provision of the Federal Civil False Claims Act that allows a private citizen to file a suit in the name of the U.S. Government charging fraud by government contractors and other entities who receive or use government funds, and share in any money recovered.[2]

Registered Nurse (RN): In California, a registered nurse (RN) is one who is licensed through the California Board of Registered Nursing. In addition to supervising licensed vocational nurses and nursing aides, RNs have the broadest scope of practice among nursing staff.

Reinsurance/Reinsurer: The purchase of insurance by an insurance company from another insurance company (reinsurer) to provide it protection against large losses on cases it has already insured.

Reported event: Any concern or alleged violation against a health facility or provider under the jurisdiction of DHS L&C reported from any source, including **facility-reported or unusual occurrences** (See Complaint). Initially when a call or letter is received, it is a reported event. The Health Facilities Evaluator Supervisor determines if the reported event requires an onsite investigation.

Reserve: An amount representing liabilities kept by an insurer to provide for future commitments under policies outstanding. (2) An amount allocated for a special purpose. Note that a reserve is usually a liability and not an extra fund.

Residential Care for the Elderly (RCFE): In California, a facility licensed by the Department of Social Services that provides care, supervision and assistance

with activities of daily living, such as bathing and grooming. RCFEs may also provide incidental medical services under special care plans. The facility provides services to persons 60 years of age and over and persons under 60 with compatible needs. RCFEs may also be known as assisted living facilities, retirement homes, and board and care homes. The facilities can range in size from 6 beds or less to over 100 beds.

Residual market: A source of insurance available to applicants who are unable to obtain insurance through ordinary methods in the voluntary market.

Resident Assessment Instrument: was developed by the federal government to help facility staff to gather definitive information to be addressed in an individualized care plan. The RAI consists of three elements:

- **Minimum Data Set (MDS)** – core set of screening, clinical and functional status elements that form the foundation of the ocmprehensive assessment of all residents.
- **Resident Assessment Protocols (RAPs)** – structured problem-oriented frameworks for organizing MDS information.
- **Utilization Guidelines** – Instructions concerning when and how to use the RAI.

Retention: The net amount of risk retained by an insurance company for its own account or that of specified others, and not reinsured.

Risk management: Procedures to minimize the adverse effect of a possible financial loss by identifying potential sources of loss, measuring the financial consequences of a loss occurring, and using controls to minimize actual losses or their financial consequences.

Risk Retention Group (RRG): An alternative form of insurance in which members of a similar profession or business band together to self insure their risks. (Also see Table 3, page 24).

Self-insured: A corporation or entity establishes reserves to pay for potential claims, rather than purchasing outside. The claims are internally managed by the organization.

Self-pay: The responsibility for payment of nursing home costs is that of the resident or her or his authorized representative.

Short-tail: Business on which claims generally arise and are settled quickly.

Skilled nursing facility (SNF): The legal term for a health facility that provides continuous skilled nursing care and supportive care to those whose primary health care need is the availability of skilled nursing care on an extended basis.

A SNF can be freestanding, meaning the facility is licensed as a stand-alone facility. There are also distinct-part SNFs, which function as a wing or unit within another kind of licensed health facility, most commonly, acute-care hospitals. The term "nursing home" is sometimes used interchangeably for SNF. (See also Table 1, page 4).

Skilled Nursing Facility Financial Solvency Advisory Board (SNFFSAB): Part of the Aging with Dignity Initiative (provisions in AB 1731). DHS will convene a SNF Financial Solvency Advisory Board, consisting of eight members with expertise in the fields of health economics, accountancy, consumer advocacy, employee organizations, and health care management. The Board will recommend appropriate financial standards for facilities to meet to qualify for a license, and methods to monitor facility financial status, in order to promote early intervention when facilities begin to face financial problems that could lead to disruptions in care.

Soft market: That part of the insurance sales cycle in which competition is at a maximum as insurance companies use their excess capacity to sell more policies at lower prices.

State Citation: See **Citation**.

Statement of Deficiency Form, or Form 2567: A form utilized to outline the survey or complaint findings. The Form 2567 is sent to the health facility. If there are deficiencies, the facility prepares its POC which the State must approve. Survey staff conduct a follow-up review to verify that corrections have been made. If a facility does not submit an acceptable POC, DHS takes appropriate enforcement actions. If DHS determines that deficiencies identified on a survey warrant a State Citation, a separate Citation document is written and financial penalties are assessed. The facility is also required to submit an acceptable POC on a Form 2567 for the compliance issue identified in the Citation.

Surplus lines: (1) A risk or a part of a risk for which there is no normal insurance market available. (2) Insurance written by non-admitted insurance companies.

Surveys: The California Department of Health Services' Licensing and Certification Program determines the compliance of health facilities with the applicable licensing and certification requirements through unannounced team inspections called "surveys." There are several kinds of surveys, including initial certification or licensure surveys that are required before a facility can gain either a license to operate or certification for reimbursement; regular surveys conducted on a periodic basis to evaluate compliance; and surveys conducted in response to a complaint investigation that finds cause for closer examination of a facility's practices. During the survey process, the survey team examines facility records; conducts staff and patient interviews; and makes careful observations of patient care, staff and management activities and interaction, and facility operations.

Tail coverage: Coverage that can be purchased after the expiration of a claims-made liability policy that extends for a period of time, with or without limit, the right to report events that occurred before the policy was terminated.

Umbrella liability: Insures losses in excess of amounts covered by other liability insurance policies; also protects the insured in many situations not covered by the usual liability policies.

Underwriter: (1) A company that receives the premiums and accepts responsibility for the fulfillment of the policy contract; (2) The company employee who decides whether or not the company should assume a particular risk; (3) The agent who sells the insurance policy.

Underwrites/Underwriting: The process of selecting risks for insurance and determining in what amounts and on what terms the insurance company will accept the risk.

Underwriting profit or loss: The amount of money that an insurance company gains or loses as a result of its insurance operations. It excludes investment transactions and federal income taxes.

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[1] Ahrens, op. cit., p. 86.
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APPENDIX B

ASSEMBLY BILL 430, CARDENAS

(Chapter 171, Statutes of 2001)

SEC. 53.5. The State Department of Health Services shall convene a workgroup with the Department of Insurance, the Office of Statewide Health Planning and Development, and the Department of Finance and shall submit a report by March 1, 2002, to the appropriate committees of the Legislature, on the availability and cost trends for general liability and professional liability and professional liability insurance for long term care providers in California. This report should focus on elements that include, but are not limited to, all of the following:

(a) The number and cost of claims and trends

(b) Trends in average long-term care liability premiums.

(c) Projections on future cost of claims and premiums based on past and current loss experience.

(d) Identification of the factors contributing to trends in claims, costs, and premiums related to general liability and professional liability insurance for long-term care providers.

(e) A review of actions taken in other states related to general liability and professional liability insurance for long-term care providers.

(f) Policy recommendations related to the availability and cost of general liability and professional liability insurance for long-term care providers.

APPENDIX C.

STAKEHOLDERS

The following organizations and/or individuals were invited to submit materials for consideration in the preparation of this report.

Aetna, Incorporated

Alliance of American Insurers

American Association of Retired Persons (AARP) – California Office and National Headquarters

American Federation of State, County, County and Municipal Employees District Council 57

American Insurance Association

American Nurses Association of California

Assemblymember Helen Thomson, Chair of the Assembly Health Committee

Assemblymember Thomas Calderon, Chair of the Assembly Insurance Committee

Association of California Insurance Companies

Beverly Healthcare

California Assisted Living Facilities Association

California Association for Nursing Home Reform

California Association of Health Facilities

California Association of Homes and Services for the Aged

California Commission on Aging

California Department of Aging (Triple A Council of California) Director's Office

California Department of Justice, Bureau of Medi-Cal Fraud and Elder Abuse

California Department of Insurance

California Department of Social Services, Community Care Licensing

California Healthcare Association

California HealthCare Foundation

California Licensed Vocational Nurses Association

California Life and Health Insurance Guarantee Association

California Mental Health Directors Association

California Nurses Association

California Rehabilitation Association

California State Council of Service Employees

California Wellness Foundation

Centers for Medicare and Medicaid Services

Consumer Attorneys of California

Consumers Union Southwest Regional Office

Division of State Operations, Centers for Medicare and Medicaid Services

Farmers Insurance Group

Health and Human Services Agency, Office of the Secretary, Long-Term Care Council

Health Insurance Association of America

Liberty Mutual Insurance

Little Hoover Commission

MBIA Insurance Investor Relations

National Senior Citizens Law Center

Senator Deborah Ortiz, Chair of the Senate Health and Human Services Committee

Senator Jackie Speier, Chair of the Senate Insurance Committee

Services Employees international Union, California State Council Western Regional Office

Sierra Health Foundation

St. Paul Re-Morristown

University of California, Office of the President

Wausau Insurance Companies

APPENDIX D.

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APPENDIX E.

Aging With Dignity

FACT SHEET

California has the fastest growing population in the country, and the fastest growing segment of California's population is persons aged 85 and over. The number of people over 60 years of age will grow from 4.9 million in 2000 to 9.0 million by 2020.

In January 2000, Governor Gray Davis introduced his Aging with Dignity Initiative to expand in-home and community-based care options to assist elderly Californians and disabled adults. Included in statewide efforts to provide expanded alternatives to nursing homes, Governor Davis' Initiative also enhances the quality of care provided in California's nursing home facilities.

"Our approach - consistent with our values – should be to keep families together by providing the services older Californians need to remain in their own homes, instead of nursing homes."

- Governor Gray Davis

In signing the State's budget for fiscal year 2000/01, the Governor approved nearly $500 million in total funding (nearly $270.5 in General Fund monies) to assist seniors and younger adults with functional impairments his Initiative. These funds have been distributed among several departments within the California Health and Human Services Agency.

Highlights:

Helping Seniors and Disabled Adults Live Independent Lives

The Aging with Dignity Initiative builds on existing efforts to help seniors and disabled adults remain at home and live independently in their own community, including:

- **Long-term care tax credit (AB 2871, Correa):** Eligible caregivers may now receive a $500 tax credit for families caring for seniors and disabled adults at home. This credit will help offset the direct cost of long-term care, such as home health visits, adult day care, and home safety modifications, as well as indirect costs, such as unpaid leave that some caregivers must take.

- **Long-term care innovation grants:** One-time challenge grants totaling $14.2 million to fund innovative models that provide more options to seniors and younger adults with functional impairments in need of long-term care assistance to remain in their own homes and communities.

- **Senior Housing Information and Support Center (AB 1846, Lowenthal):** Provides information concerning housing options and home modification alternatives that allow seniors and disabled adults to live independently or with their families. This program promotes education and training for professionals who work directly with seniors and disabled adults to keep them living as independently as possible. In addition, the program serves as a clearinghouse for information for seniors and disabled adults as well as their families on available innovative resources and senior services. The budget (2000 session) includes $1 million for these purposes.

- **Senior Wellness Education Campaign:** This campaign, funded at $1 million, offers information to seniors, their families and health professionals on healthy aging practices, and information about community-based and in-home care alternatives to institutional care.

- **Allow low-income seniors and disabled individuals to keep more income for at-home care:** Reduces out-of-pocket payments many seniors have to contribute toward their own medical costs before Medi-Cal is available. This extends "no cost" Medi-Cal to about 13,000 aged and disabled persons with income up to 100 percent of the federal poverty level (FPL) and reduces the share of cost for those above the FPL. The

budget includes a total of $47 million ($23.5 million General Fund) for this new program.

- **In-home supportive services increases:** Increases wages to in-home care providers up to $8.10 per hour and, if revenue targets are met, up to $12.10 per hour. Also, extends health benefits to in-home care workers for the first time. Total funding for this is $354.4 million (including $167 million General Fund).

Long Term Care Workforce

The initiative will increase the number of qualified caregivers for California seniors and disabled adults by providing job training resources for recruitment and training of staff in the long-term care industry, instituting a system of quality incentive awards, and increasing Medi-Cal rates, as follows:

- **Train Employees to be Caregivers:** The budget includes $25 million of federal Workforce Investment Act funds to train current or prospective employees in the caregiver industries, including nursing homes and the In-Home Supportive Services program. The budget also targets Welfare-to-Work funds for recruitment, retention, and training of these same caregivers.
- **Increase Nursing Home Employee Wages:** In addition to existing Medi-Cal cost-based rate adjustments, the Budget includes $67 million General Fund monies to provide an additional 5 percent wage increase for caregivers in nursing facilities, above the 5 percent increase provided in the 1999 Budget Act. Total funding for this effort is $132 million.
- **Review Staff-to-Patient Ratios for Nursing Homes:** The Governor has directed the Department of Health Services (DHS) to review minimum staff-to-patient ratios. DHS provided their recommendations in October 2002.

Improving Care Facilities

California is committed to improving the quality of care provided to residents in California's nursing homes. The Department of Health Services focuses enforcement activities on nursing homes that demonstrate difficulty in maintaining compliance with state and federal requirements. To further protect the most vulnerable Californians, the budget includes several initiatives to increase the number of nursing home inspections, ensure rapid response in complaint investigations, and strengthen enforcement activities, as follows:

- **Increase Unannounced Inspections of Nursing Homes (AB 1731, Shelley):** A total of $7.5 million ($3 million General Fund) and 100 positions have been added to increase the frequency and unpredictability of nursing home inspections, and inspect homes under new federally

mandated standards adopted as part of the President Clinton's Nursing Home Initiative.

- **Quality Awards for Exemplary Nursing Homes (AB 1731, Shelley):** Cash awards are available to facilities that serve high proportions of Medi-Cal patients and maintain the highest quality of patient care. The budget includes a total of $10 million ($8 million General Fund) for this purpose. Facilities will be eligible to receive awards of $20,000 to $50,000 each year.
- **Rapid Response to Nursing Home Complaints (AB 1731, Shelley):** A total of $3.9 million ($2.2 General Fund) and positions have been added to help guarantee a 24-hour response in investigating emergency complaints regarding patient care.
- **Require facilities to increase posting of the Long Term Care Ombudsman's toll-free number (AB 1731, Shelley):** All licensed facilities are required to increase posting of an 800 number for complaints regarding patient safety. The proposal includes penalties of $100 per day for noncompliance.
- **Licensure Status for Facilities that have the Most Serious Care Problems (AB 1731, Shelley):** This allows DHS to put any facility back on probation for violations of standards of care.
- **Increase Fines for Serious or Repeat Violations, and Allow for Direct Referral of Severe Violations to District Attorneys for Prosecution (AB 1731, Shelley):** Increase fines for "AA" citations, violations that cause the death of a patient, to $100,000, from the previous range of $5,000-$25,000. The initiative also calls for increased fines for a first "A" citation, violations that can cause serious harm or death or have caused serious harm, from a range of $1,000-$10,000 to a range of $2,000-$20,000.
- **Increase the Expenditure Cap on the State Health Facility Citation Fund (AB 1731, Shelley):** This fund is used for court-appointed receiverships, or to replace patient trust accounts or personal possessions that are misappropriated or destroyed. Prior to the initiative, annual revenue in the fund in excess of $1.0 million is transferred to the General Fund. This limit will be increased to $10.0 million, thereby allowing a reserve in the fund sufficient to handle several receiverships at once.

Strengthening Fiscal Standards

Strong financial solvency standards and reporting requirements are necessary to ensure that not only the facility operator, but the operator's parent company has the necessary resources to provide quality long-term care to California's frail and elderly population. The Initiative strengthens fiscal standards in the following ways:

- **Establishes a Fiscal Solvency Review Advisory Board to Review and Establish New Standards and Reporting Requirements for Nursing Facility Licensees (AB 1731, Shelley):** The State has a duty to protect residents from unnecessary transfers and disruptive closures. The budget allocates $500,000 to establish a Fiscal Solvency Review Advisory Board to recommend appropriate fiscal standards for nursing homes to prevent bankruptcies and disruptions in care.
- **Authorizes DHS to Provide for a Temporary Manager (AB 1731, Shelley):** Under existing law, for homes with severe fiscal mismanagement or substandard quality of care, the State has no intermediate sanctions or alternatives short of a court-appointed receiver. The Initiative makes statutory changes to allow appointment of a temporary state manager, paid for by the licensee.
- **Allows DHS to Recover Costs of Court Appointed Receivers from Parent Corporations or Individual Owners (AB 1731, Shelley):** The Initiative expands current law to allow the State to recover the cost of a receiver from any substandard licensee or any related corporation(s).

APPENDIX F.

MICRA AND EDACPA LEGAL REFERENCES

CALIFORNIA ELDER ABUSE & DEPENDENT ADULT CIVIL PROTECTION ACT
(Welfare & Institutions Code Sections 15600-15675)

Purpose: The purpose and legislative intent of the *Elder Abuse & Dependent Adult Civil Protection Act* was based on the recognition that elders and dependent adults may be subjected to abuse, neglect, or abandonment and that this state has a responsibility to protect these persons. (*Welfare & Institutions Code Section 15600)*

What is Elder Abuse? "'Abuse of an elder or a dependent adult' means either of the following: (a) Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering. (b) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering." (*Welfare & Institutions Code Section 15610.07)*

Definitions of Elder Abuse:
Abandonment – "Means the desertion or willful forsaking of an elder or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody." *(W&I 15610.05)*

Abduction – "Means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state…of any conservatee without the consent of the conservator or the court." *(W&I 15610.06)*

Fiduciary, or Financial Abuse – Means the taking, secreting, or appropriating an elder's money or property for a wrongful use, or with the intent to defraud, by a person who has care or custody of the elder or stands in a position of trust to the elder. *(W&I 15610.30)*

Isolation – "Means intentionally preventing an elder from receiving mail or telephone calls, wrongfully informing visitors or callers that the elder does not wish to see or talk with them; false imprisonment; physically restraining an elder from meeting with visitors.

Mental Suffering – Means fear, agitation, confusion, severe depression, or other forms of serious emotional distress resulting from threats, harassment, or other forms of intimidating behavior. *(W&I 15610.53)*

Neglect – "Means…the negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care or custody of an elder or dependent adult…that a reasonable person in a like position would exercise or the negligent failure of the person themselves to exercise that degree of care that a reasonable person in a like position would exercise." *(W&I 15610.57)*

Physical Abuse – Means the assault, battery, assault with a deadly weapon, unreasonable physical constraint or prolonged deprivation of food or water, sexual assault, sexual battery, rape, incest, sodomy, oral copulation, penetration of a genital or anal opening by a foreign object or use of physical or chemical restraint or psychotropic medication for punishment, or period longer than prescribed, or for any Purpose not authorized by a physician. *(W&I 15610.63)*

REPORTING ELDER ABUSE

Welfare & Institutions Code Section 15630(a): "Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency is a mandated reporter."

Welfare & Institutions Code Section 15630(b)(1): "Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, or neglect, or reasonably suspects that abuse shall report the known or suspected instance of abuse, by telephone immediately or as soon as practically possible, and by written report…"

REPORTING REQUIREMENTS OF AB 1731, ADDED BY STATUTE IN 2000 as HEALTH & SAFETY CODE SECTION 1418.91.

Reports of Incidents of Alleged Abuse or Suspected Abuse of Residents:

(a) A long-term health care facility shall report all incidents of alleged abuse or suspected abuse of a resident of the facility to the department immediately, or within 24 hours.
(b) A failure to comply with the requirements of this section shall be a class "B" violation.
(c) For purposes of this section, "abuse" shall mean any of the conduct described in subdivisions (a) and (b) of Section 15610.07 of the Welfare and Institutions Code.
(d) This section shall not change any reporting requirements under Section 15630 of the Welfare and Institutions Code, or as otherwise specified in the Elder Abuse and Dependent Adult Civil Protection Act, Chapter 11, (commencing with Section 15600) of Part 3 of Division 9 of the Welfare and Institutions Code.

CIVIL ACTIONS UNDER THE ELDER ABUSE & DEPENDENT ADULT CIVIL PROTECTION ACT (WELFARE & INSTITUTIONS CODE SECTION 15657)

Welfare and Institutions Code Section 15600(h) "The Legislature further finds and declares that infirm elderly persons and dependent adults are a disadvantaged class, that cases of abuse of these persons are seldom prosecuted as criminal matters, and few civil cases are brought in connection with this abuse due to problems of proof, court delays, and the lack of incentives to prosecute these suits."

The addition of Welfare and Institutions Code Section 15657 included incentives that shifted the focus to private, civil enforcement of elder abuse laws as evidenced by the language of Welfare and Institutions Code Section 15657 and 15600(j) which states; "It is the further intent of the Legislature in adding Article 8.5 (commencing with Section 15657) to this chapter to enable interested persons to engage attorneys to take up the cause of abused elderly persons and dependent adults."

Elements of Welfare & Institutions Code Section 15657:

"Where it is proven by clear and convincing evidence that a defendant is liable for physical abuse, as defined in Section 15610.63, neglect as defined in Section 15610.57, or fiduciary abuse as defined in Section 15610.30, and that the defendant has been guilty of recklessness, oppression, fraud, or malice in the commission of this abuse, in addition to all other remedies otherwise provided by law:

(a) The court shall award to the plaintiff reasonable attorney's fees and costs. The term "costs" includes, but is not limited to, reasonable fees for the services of a conservator, if any, devoted to the litigation of a claim brought under this article.
(b) …[H]owever, the damages recovered shall not exceed the damages permitted to be recovered pursuant to subdivision (b) of Section 3333.2 of the Civil Code.
(c) The standards set forth in subdivision (b) of Section 3294 of the Civil Code regarding the imposition of punitive damages on an employer based upon the acts of an employee shall be satisfied before any damages or attorney's fees permitted under this section may be imposed against an employer.

Enhanced Remedies:

The enhanced remedies under the *Elder Abuse & Dependent Adult Civil Protection Act* include the award of reasonable attorney's fees and costs to the plaintiff and a conservator, if any, devoted to a claim brought under the *Elder Abuse & Dependent Adult Civil Protection Act*, general damages for a decedent's pain and suffering in an amount no greater than $250,000 per Civil Code Section 3333.2, and the award of Punitive Damages based on Section 3294 of the Civil Code.

CIVIL CODE SECTION 3333.2
(MEDICAL INJURY COMPENSATION REFORM ACT [MICRA])

The Medical Injury Compensation Reform Act [MICRA] of 1975 placed a limit of $250,000 on the non-economic losses that could be recovered against a health care provider for a negligence cause of action.

Elements of Civil Code Section 3333.2:

(a) In any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other non-pecuniary damage.
(b) In no action shall the amount of damages for non-economic losses exceed two hundred fifty thousand dollars ($250,000).
(c) For the purposes of this section:

    (1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;
    (2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or a licensed hospital."

STANDARD SET FORTH IN CIVIL CODE SECTION 3294
FOR PUNITIVE DAMAGES UNDER
WELFARE AND INSTITUTIONS CODE SECTION 15657(c)

Elements of Civil Code Section 3294:

(a) In an action for the breach of an obligation not arising from contract, where it is proven by clear and convincing evidence that the defendant has been guilty of oppression, fraud, or malice, the plaintiff, in addition to the actual damages, may recover damages for the sake of example and by way of punishing the defendant.

(b) An employer shall not be liable for damages pursuant to subdivision (a), based upon acts of an employee of the employer, unless the employer had advance knowledge of the unfitness of the employee and employed him or her with a conscious disregard of the rights or safety of others or authorized or ratified the wrongful conduct for which the damages are awarded or was personally guilty of oppression, fraud, or malice. With respect to a corporate employer, the advance knowledge and conscious disregard, authorization, ratification or act of oppression, fraud, or malice must be on the part of an officer, director, or managing agent of the corporation.

(c) As used in this section, the following definitions shall apply:

(1) "Malice" means conduct which is intended by the defendant to cause injury to the plaintiff or despicable conduct which is carried on by the defendant with a willful and conscious disregard of the rights or safety of others.

(2) "Oppression" means despicable conduct that subjects a person to cruel and unjust hardship in conscious disregard of that person's rights.

(3) "Fraud" means an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury.

APPLICATION OF CODE OF CIVIL PROCEDURE SECTION 425.13 TO PUNITIVE DAMGE CLAIMS BROUGHT UNDER THE ELDER ABUSE & DEPENDENT ADULT CIVIL PROTECTION ACT (W&I CODE 15657) AND CIVIL CODE SECTION 3294

Code of Civil Procedure Section 425.13:

(a) In any action for damages arising out of the professional negligence of a health care provider, no claim for punitive damages shall be included in a complaint or other pleading unless the court enters an order allowing an amended pleading that includes a claim for punitive damages to be filed. The court may allow the filing of an amended pleading claiming punitive damages on a motion by the party seeking the amended pleading and on the basis of the supporting and opposing affidavits presented that the plaintiff has established that there is a substantial probability that the plaintiff will prevail on the claim pursuant to Section 3294 of the Civil Code. The court shall not grant a motion allowing the filing of an amended pleading that includes a claim for punitive damages if the motion for such an order is not filed within two years after the complaint of initial pleading is filed or not less than nine months before the date the matter is first set for trial, whichever is earlier.

(b) For the purposes of this section, "health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

APPENDIX G.

ATTORNEY GENERAL, OFFICE OF FRAUD AND ABUSE LEGAL REFERENCES

Elder Abuse Statutes (Criminal)

CODE SECTION	DESCRIPTION	PENALTY
PENAL CODE § 187 (Murder)	▪ A human being was killed ▪ The killing was unlawful ▪ The killing was done with malice aforethought or occurred during the commission of a felony inherently dangerous to human life	▪ Death ▪ Life Without Possibility of Parole ▪ 25 Years to Life
PENAL CODE § 261 (Rape)	Act of sexual intercourse (with person not spouse) under any of the following circumstances: ▪ Person is incapable, because of mental disorder or developmental or physical disability, of giving legal consent and this is known or reasonably should be known to person committing act ▪ Accomplished against person's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury ▪ Person prevented from resisting by intoxicating or anesthetic substance ▪ Person unconscious of nature of the act and this is known to accused	▪ State prison 3, 6 or 8 Years
PENAL CODE § 288(a); (b)(2);(c)(2) (Lewd or Lascivious Acts)	▪ A person willfully and lewdly commits any lewd or lascivious act, with intent of arousing, appealing to, or gratifying the lust, passions, or sexual desires of that person. ▪ Person is a caretaker and commits act upon dependent adult by use of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim ▪ Person is a caretaker and commits act upon dependent adult is guilty of a public offense	▪ Felony state prison 3, 6 or 8 years and $10,000 fine; State prison 1, 2 or 3 years or 1 year county jail
PENAL CODE § 289 (Sexual Penetration)	▪ A person commits an act of sexual penetration ▪ Against victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury ▪ Victim is incapable, because of mental disorder or developmental or physical disability, of giving consent and this is known or reasonably should be known to person committing act	▪ State prison 3, 6 or 8 years

PENAL CODE § 368(b)(1)(2)(3) (Causes or permits infliction of physical pain or mental suffering on elder or dependent adult under circumstances or conditions likely to produce great bodily harm or death)	▪ A person, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits an elder or dependent adult to suffer With knowledge that he or she is an elder or dependent adult ▪ Unjustifiable physical pain or mental suffering	▪ One year county jail and $6,000 fine or state prison two, three, or four years ▪ If victim suffers great bodily injury then additional state prison: ▪ 3 years if victim under 70 years ▪ 5 years if victim 70 years or older ▪ If defendant causes death of victim then additional state prison: ▪ 5 years if victim under 70 years ▪ 7 years if victim 70 years or older
PENAL CODE § 368(c) (Causes or permits infliction of physical pain or mental suffering on elder or dependent adult under circumstances or conditions not likely to produce great bodily harm or death)	▪ A person, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits an elder or dependent adult to suffer With knowledge that he or she is an elder or dependent adult ▪ Unjustifiable physical pain or mental suffering	▪ Misdemeanor
PENAL CODE § 368(d) (Violates provision of law proscribing theft or embezzlement not a caretaker)	▪ A person, not a caretaker, violates provision of law proscribing theft or embezzlement with respect to property of an elder or dependent adult ▪ With knowledge that he or she is an elder or dependent adult	▪ When value of property taken exceeds $400: ▪ Misdemeanor or felony: One year county jail and $1,000 fine ▪ When value of property taken does not exceed $400: ▪ One year county jail and $1,000 fine
PENAL CODE § 368(e) (Violates provision of law proscribing theft or embezzlement caretaker)	▪ A caretaker violates provision of law proscribing theft or embezzlement with respect to property of an elder or dependent adult	▪ When value of property taken exceeds $400: ▪ Misdemeanor or felony: One year county jail and $1,000 fine ▪ When value of property taken does not exceed $400: ▪ One year county jail and $1,000 fine

PENAL CODE § 422 (Elements of Offense Willfully threatens to commit a crime which will result in death or great bodily injury)	▪ A person willfully threatens to commit a crime which ▪ Will result in death or great bodily injury to another ▪ With specific intent that the statement ... is to be taken as a threat ▪ Causes person reasonably to be in sustained fear for his or her own safety or for his or her immediate family's safety	▪ County jail not to exceed one year or state prison
HEALTH & SAFETY CODE § 1290 (Violations, Penalties Relating to Operation or Maintenance of LongTerm Healthcare Facilities	▪ Willfully or repeatedly violating chapter or rule or regulation adopted under chapter relating to operation or maintenance of longterm health care facility	▪ Misdemeanor $2,500 fine and 180 days county jail
WELFARE & INSTITUTIONS CODE § 15630 (Mandated Reporters of Abuse)	▪ Defines mandated reporters ▪ Known or suspected abuse of elder or dependent adult: ▹ Physical ▹ Abandonment ▹ Isolation ▹ Financial ▹ Neglect ▹ Reporting requirements	▪ Failure to report misdemeanor: ▪ Six months county jail and $1,000 fine Failure to report felony where abuse results in death or great bodily injury: ▪ One year county jail and $5,000 fine

Elder Abuse Statutes (Civil)

CODE SECTION	DESCRIPTION	PENALTY
BUSINESS & PROFESSIONS CODE §17200 *et seq.* (Unfair Business Practice) and §17500 *et seq.* (Unfair Business Practice; Deceptive Advertising)	▪ Any unlawful, unfair or fraudulent business act or practice	▪ Injunction; civil penalty up to $2,500 per violation
GOVERNMENT CODE §12650 *et seq.* (False Claims)	▪ Knowingly presents or causes to be presented a false claim to the state for money, property or services	▪ Civil penalty of treble damages and up to $10,000 for each false claim

Elder Abuse Statutes (Civil Private Actions)

CODE SECTION	DESCRIPTION	PENALTY
BUSINESS & PROFESSIONS CODE § 17200 *et seq.* **and** § 17500 *et seq.* (Unfair Business Practice; Deceptive Advertising)	▪ Any unlawful, unfair or fraudulent business act or practice; deceptive, false or misleading advertising	▪ Restitution; injunctive relief (damages and civil penalties not available to private litigants)
CIVIL CODE § 3345 (Treble Fines, Penalties, or Remedies)	▪ Treble fines, penalties, or remedies allowed in actions brought on behalf of senior citizens or disabled persons which involve unfair or deceptive acts or practices or unfair methods of competition	▪ Treble fines, penalties, or remedies
GOVERNMENT CODE § 12650 *et seq.* (False Claims)	▪ Knowingly presents or causes to be presented a false claim to the state for money, property or services; Govt. Code § 12652(c)(1) provides authority for private person to bring action on behalf of state	▪ Civil penalty of treble damages and up to $10,000 for each false claim
WELFARE & INSTITUTIONS CODE § 15600 *et seq.* (Elder Abuse and Dependent Adult Civil Protection Act)	▪ If clear and convincing evidence that a defendant is liable for abuse or neglect of an elder or dependent adult, and defendant has been guilty of recklessness, oppression, fraud, or malice, the elder or dependent adult is entitled to certain enhanced remedies	▪ Punitive damages; reasonable attorney's fees and costs; claim for general damages for pain and suffering survives death of victim

APPENDIX H.

NATIONAL CONFERENCE OF STATE LEGISLATURES
EMPLOYMENT AND INSURANCE PROGRAM

Medical Liability Statutes
State Summary Chart

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Alabama	§6.5.482 (1975, 1993) 2 years from date of injury or 6 months from reasonable discovery; no suit may be brought 4 years after date of injury; minors under 4 by age 8 if statute would have otherwise expired by that time	§6.5.544 (1987) $400,000 limit on non-economic damages, including punitive damages; §6.5.547 $1 million limit on total damages (court decision upheld cap only in wrongful death actions); §6-11-21 $250,000 cap on punitive damages except for wrongful death and suits alleging patterns of intentional wrongful conduct, actual malice or defamation[2]	§6.5.545 (1987) Discretionary offset; allows the jury to be informed if medical bills and/or lost wages have been paid by a third party	§6.5.543 (1987) Mandatory periodic payment of future damages in medical injury cases in excess of $150,000		§6.5.548(1997) Expert witness must be certified in same specialty as defendant and must have practiced within previous year		Alabama Supreme Court upheld constitutionality of statute of limitations in *Barlow v. Humana*, 495 So. 2d 1048 (1986); *Tucker v. Nichols*, 431 So 2d 1263 (1983); *Reese v. Fite Memorial Hospital*, 403 so 2d 158 (1981); non-economic damages portion of damage awards limitations ruled unconstitutional in *Moore v. Infirmary Assoc.*, No. 89-1087, Sp & 27, 1991; cap on total damages, excluding wrongful death, overturned in *Ray v. Anesthesia Assoc.*, P.C., 674 So.2d 525 (Ala. 1995); punitive damages cap ruled unconstitutional in *Henderson v. Alabama Power Co.*, 627 So. 2d 878 (1993); non-medical malpractice statute similar to collateral source rule struck down in *American Legion Post No. 57 v. Leahey*, 681 So. 2d 1337 (1996)
Alaska	§09.10.070 (1962) 2 years from discovery of injury; tolled by disability	§09.17.010 (1997) For injuries after Aug. 7, 1997, non-economic damages cap greater of $400,000 or plaintiff's life expectancy, in years, multiplied by $8,000; for severe injury, the greater of $1 million and life expectancy in years times $25,000; §9.17.020 (1997) punitive damages cap greater of $500,000 or 3 times compensatory damages, whichever is greater, unless malicious action, then greater of $7 million or 4 times compensatory damages; 50% of punitive damages to state fund	§09.55.548 (1992) Mandatory offset of collateral sources, except federal program benefits requiring subrogation and life insurance	§09.55.548 (1976) Discretionary periodic payment of future damages for medical treatment, care or custody, loss of future earnings, or loss of bodily function	§09.55.536 (1976) Mandatory submission of claims to pretrial screening panel, unless court waives this requirement or parties agree to arbitrate; results of screening admissible at later trial	§09.20.185 (1997) Expert witnesses must be licensed and trained in the defendant's discipline and certified by a board recognized by the state		Alaska Supreme Court upheld constitutionality of pretrial screening panels in *Keyes v. Humana Hospital Alaska, Inc.*, 750 p. 2d 343 (1988)

[1] Expert witness rules commonly established by case history. Summary chart includes only rules established by statute.
[2] Underline indicates statutes overturned by decisions of court; see *Case History* for specific citation.

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Arizona	§12.502, 542 (1971, 1984) 2 years from injury or death; foreign object or intentional fraud: 1 year from discovery; minor or unsound mind: statute begins upon removal		§12.565 (1976, 1984) Discretionary offset; evidence of collateral sources of payment for economic damages admissible at trial	§12.582 May elect for periodic payments made pursuant to court rule; claim for future damages is effective unless objecting party shows trial or arbitration should not be conducted			§12.568 (1976) Upon request by a party, the court will review the reasonableness for each party's attorney fees	Arizona Supreme Court upheld constitutionality of collateral source rule and mandatory pretrial screening panel requirement in *Eastin v. Broomfield*, 570 P.2d 744 (1977); periodic payments statute ruled unconstitutional in *Smith v. Myers*, 191 Ariz. 11, 887 P.2d 541 (1994)
Arkansas	§16.114.203 (1979, 1991) 2 years from the date of injury; foreign objects: 1 year from discovery; minors: before age 9, until age 11; plaintiff must bring suit within 1 year from date of removal of disability			§16.114.208 (1979) Discretionary periodic payment of damages over $100,000; upon death of claimant, court may deduct future pain and suffering and care expenses		§16.114.207 (1979) Testimony by experts whose compensation depends upon outcome of suit prohibited		
California	Civ. Proc. §340.5 (1975) 3 years after injury or 1 year after discovery, whichever is first; in no even more than 3 years after injury, unless caused by fraud, concealment, or a foreign object; minor under age 6: 3 years or before age 8, whichever is longer; tolled for foreign body cases until reasonable discovery	Civ. §3333.2 (1975) $250,000 limit for non-economic damages	Civ. §3333.1 (1975) Discretionary offset; evidence of collateral sources may be introduced at trial	Civ. Proc. §667.7 (1975) Mandatory periodic payment of future damages award exceeding $50,000, upon request of party; payments to continue after death of plaintiff to parties to whom judgement creditor owed a duty of support			Bus. & Prof. §6146 (1975, 1987) Sliding scale fees may not exceed 40% of the $50,000, 1/3 of the next $50,000, 25% of the next $500,000, and 15% of damages exceeding $600,000	California Supreme Court upheld constitutionality of damage awards limits and collateral source rules in *Fein v. Permanente Medical Group*, 695 P.2d 665 (1985); periodic payment of damage awards upheld in *American Bank and Trust Co. v. Community Hospital of Los Gates . Saratoga, Inc*, 683 P.2d 670 (1984); attorney fees statute upheld in *Roa v. Lodi Medical Group, Inc.*, 211 Cal. Rptr. 77 (1985); additional attorneys' fees provisions rejected by voters in 1996

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Colorado	§13.80.102(5) (1988) 2 years from date of accrual; in no event more than 3 years from act; foreign objects: 2 years from discovery; minors under age 6 must bring claim before age 8	§13.21.302 (1988) $1million limit for damages against a hospital or physician; non-economic damages limited to $250,000; court may increase limit in certain situations; §13.21.203 (1989) permissible recovery for wrongful death limited to $250,000; §13.64.302.5(5) (1990) no punitive damages against a physician for adverse outcome of prescription, medically prescribed (1991) or experimental drugs (1991) where FDA protocol was followed; §13-21-102 (1990) punitive damages may not exceed actual damage award; court may increase punitive damages to 3 times in certain situations	§§13.21.111.6 (1986) Mandatory offset for sources not contracted by and paid for by the claimant	§13.64.203 (1988) Mandatory periodic payment of future damage awards exceeding $150,000	§13.22.402; §13.22.311, 401-409 (1988) Mandatory screening for claims of $50,000 or less by "arbitration panel"; findings of panel not admissible at trial; court may require mediation of medical injury claims	§13.64.401 Expert witness must be licensed physician and substantially familiar with standard of care on date of injury; §13.20.602 (1988) claimant must file certificate of review which states that an expert was consulted and is competent to testify		Colorado Supreme Court upheld constitutionality of non-economic damage awards cap in *Scholz v. Metropolitan and Pathologists*, P.C. No. 92.8A277, Co. Supreme Court, April 26, 1993
Connecticut	§52.584 (1969) 2 years from discovery; no more than 3 years after act; §52.555 (1991) wrongful death: 2 years from death; no more than 5 years from disputed act or omission		§52.225a (1985) Mandatory offset; court reduces award by collateral sources of payment received by plaintiff, but credits plaintiff with any premiums paid	§52.225d (1987) Discretionary periodic payment of all damages in excess of $200,000; the parties have 60 days to reach payment terms for damages over $200,000; if no agreement is reached, a lump sum is awarded	§§38a-56, 19f (1977) Voluntary pretrial screening; unanimous findings of panel members admissible at trial	§52.184c(d) (1986) Expert witness must be licensed physician practicing for 5 years before date of injury	§52.251c (1986) Sliding scale fees may not exceed: third of first $300,00; 25% of next $300,000; 20% of next $300,000; 15% of next $300,000; and 10% of damages exceeding $1.2 million	
Delaware	§18.6856 (1976) 2 years from injury; 3 years from discover if latent injury; minor: age 6 or same as adult	§18.6855 (1976) Punitive damages may be awarded only on finding of malicious intent to injure or will or wanton misconduct	§18.6862 (1976) Discretionary offset; evidence of "public collateral sources of payment" may be introduced (evidence of life insurance or private collateral sources of compensation benefits excluded)	§18.6864 (1976) Discretionary periodic payment of future damages in medical injury actions only; compensation for future pain and suffering and future expenses deducted from balance of payments on death of plaintiff	§18.6801-6814 (1976) submission to review panel on demand; negative opinion admissible as prima facie evidence at any subsequent trial; expert witness testimony may be required for panel	§18.6853-6854 (1976) Required to establish deviation from applicable standard of care unless panel found negligence to have caused injury; experts knowledge of similar locality in order to testify	§18.6865 (1976) Sliding scale fees may not exceed: 35% of first $100,000; 25% of next $100,000; and 10% of damages exceeding $200,000	

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
District of Columbia	§12.301-2 (1995) 3 years from reasonable discovery; wrongful death: 1 year from death							
Florida	§95.11 (1972, 1980) 2 years from injury or discovery, no more than 4 years from injury; minors: age 8; if fraud, concealment of injury or intentional misrepresentation prevented discovery within 4 year period, 2 year limit from discovery, not to exceed 7 years after the act	§768.73 (1997) Punitive damages in excess of 3 times economic damages or $500,000 presumed excessive; §766.207, 209 (1988) where parties agree to binding arbitration, (1) net economic damages for wage loss including to 80% of wage loss and earning capacity; (2) non-economic damages limited to maximum $250,000 calculated for capacity to enjoy life; where the plaintiff refuses to arbitrate, non-economic damages may not exceed $350,000 plus net economic damages including past and future medical expenses and 805 of wage loss and loss of earning capacity; no limits where defendant refuses to arbitrate	§768.76 (1986) Mandatory offset by court, except for those collateral sources for which there are subrogation rights; §§766.207, 209 (1988) rule extends to binding arbitration cases	§768.78 (1986) Mandatory periodic payment of future damage award exceeding $250,000, at the request of a party; defendant may elect to pay lump sum for future economic losses and expenses reduced to present value; §766.207(7)(c) (1988) damages for future economic losses awarded by arbitration payable on periodic basis under 766.202(8)	§766.106-107 (1985) Court may require submission of claim to an arbitrary panel; result not admissible in a later trial	§766.102(c) (1988) Expert testimony by licensed physician in same practice or practicing for 5 years before claim filed	Atty. Conduct Reg. 4-1.5(f)(40(b) Separate sliding scales for cases settling before filing an answer or appointing an arbitrator, cases settling before or after going to trial, and cases in which liability is admitted and only damages contested; 5% extra for cases appealed	Voluntary binding arbitration caps found unconstitutional in *Univ. of Miami School of Medicine v. Echarte*, no. 90.982, Fla. App. Ct., 3rd district, June 11, 1991; 1975 statute, without the subrogation exception, upheld in *Pinillos v. Cedars of Lebanon Hospital Corp.*, 403 So. 2d 365 (1981) and *Smith v. Department of Insurance*, 507 So. 2d 1080 (Fla. 1987); earlier pretrial screening panel provision found unconstitutional in *Aldana v. Holub*, 381 So. 2d 231 (Fla. 1980)
Georgia	§9.3.71-73, 9.63 (1992) 2 years from injury or death; in no event longer than 5 years from act or death; foreign object: 1 year from discovery; minors: age 7 and, and in no event later than age 10; agreement by parties to arbitrated tolls statute	§51.12.5.1 (1992) $250,000 cap on punitive damages, unless demonstrated intent to harm	§51.12.1 (1987) Collateral sources evidence admissible to jury		§9.9.61-63 (1997) Voluntary arbitration subject to court review; binding if prior agreement to make it so	§9.11.9.1 (1998) Complaint must generally contain an affidavit of an expert stating that the facts justify a claim of negligence		Georgia Supreme Court upheld as constitutional statute of repose in *Craven v. Lowndes County Hospital Authority*, 263 Ga. 657, 437 S.E.2d 308 (1993); collateral source rule found unconstitutional in *Georgia Power Co. v. Falagan, et al.*, No S90A1245, Ga. Sup. Ct. (April 1991); *Dentor v. Con-Way Southern Express, Inc.*, 261 Ga. 41, 402 S.E.2d 269 (1991)
Hawaii	§657.7.3, 671.18 (1973, 1986) 2 years from discovery, not to exceed 6 years from act; minors: age 10 or within 6 years, whichever is longer; arbitration tolls statute until 60 days after the panel's decision is delivered but for no more than 18 months	§663.8.5, 8.7 (1986) $375,000 cap for pain and suffering damages; excludes mental anguish, disfigurement, loss of enjoyment of life, and loss of consortium			§601-20 (1986) Mandatory nonbonding arbitration for all cases involving $150,000 or less; §671.11-20 (1976) mandatory submission of medical injury claim to medical claim conciliation panel; results not admissible at trial		§607.15.5 (1986) Attorney fees must be approved by the court	

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Idaho	§5.219 (1971) 2 years from injury; foreign object: 1 year from reasonable discovery or 2 years from injury, whichever is later	§6.1603 (1987) $400,000 cap on non-economic damages in any tort action, unless personal injury cause by "willful or reckless misconduct" or felony; cap adjusted annually according to the state's adjustment of the average annual wage; §6.1606 (1990) removed 1992 sunset	§6.1606 (1990) Mandatory offset of collateral sources except for federal benefits, life insurance and subrogation rights	§6.1602 (1987) Discretionary periodic payment of future damage awards exceeding $100,000, excluding cases involving intentional tort, gross negligence, or extreme deviation from standards unless agreed to by claimant	§6.1001-1011 (1976) mandatory submission of claim to hearing panel; results not admissible at trial	§6.1012 (1990); Claimant must prove negligence by direct expert testimony; §6.1013 (1976) Expert witness must have knowledge of community standards		Idaho Supreme Court upheld constitutionality of statute of limitations in *Homes v. IWASA*, 657 P.2d 476 (1983); earlier damage awards limit applying only to medical liability overturned in *Jones v. State Board of Medicine*, 555 P.2d 399 (Idaho 1976) *cert denied* 431 U.S. 914 (1977)
Illinois	§735.5/13.212 (1992) 2 years from discovery but not more than 4 years from act; statute tolled for disability (where plaintiff is insane, mentally ill or imprisoned); minors: 8 years after act but not after age 22; §740.180/2 (1995) wrongful death: 2 years from death, if statute of limitation on personal injury still valid at time of death	§735.5/2.1115.1 (1997) $500,000 cap on non-economic damages; §735.5/1115 (1985) punitive damages not recoverable in medical malpractice cases	§735.5/2.1205 (1992) Claimant may apply within 30 days of judgment for 50% reduction of collateral payments for lost wages or disability benefits; 100% of medical benefits (with exceptions), but not more than 50% of total award	§735.5/2.1705-6 (1985) Voluntary or discretionary periodic payment of future damages awards over $250,000		§735.5-8 Plaintiff required to provide affidavit stating that competent expert has been consulted	§110.2.1114 (1985) Sliding scale fees may not exceed third of first $150,000; 25% of next $850,000 and 20% of damages exceeding $1 million; §735.5/2.1114 (1992) attorney may apply to the court for additional compensation under certain circumstances	Illinois Supreme Court upheld constitutionality of statute of limitations in *Anderson v. Wagner*, 402 N.W. 2d 560 *app. Dismissed*, 449 U.S. 807 (1979), *reversing Woodward v. Burnham City Hospital*, 377 N.E. 2d 290 (1987); non-economic damage award cap struck down in *Best v. Tayor Machine Works*, Nos. 81890-81893, 1997 WL 777822 (Dec. 18, 1997); similar 1975 statute overturned in *Wright v. Central Du Page Hospital Association*, 347 N.E. 2d 736 (1976); pretrial screening panel provision struck down and periodic payment of damage awards upheld in *Bernier v. Burris*, 497 N.E. 2d 763 (1986)
Indiana	§34-18-7-1 (1998) 2 years from act, omission, or neglect; minors: under age 6 until age 8; applies regardless of minority or other disability	§34-18-18-1 (1998) For acts prior to 1990, $100,00 cap from a single provider and $500,000 cap from all providers and Patient Compensation Fund (PCF); as of 1990, $750,000 cap for all providers and PCF; as of July 1999, $250,000 limit for each provider and a $1,250,000 for all providers and PCF; only 1 recovery per single injury; no damage caps in cases not brought against qualified providers	§34.44.1.2 (1998) Collateral sources except life insurance, insurance payments made directly to plaintiff, plaintiff's family or state/federal benefits paid before trial admissible at trial	§34.18.15.1 (1985) Discretionary periodic payment	§34.18.8.4-6 (1975) mandatory submission of claim, unless parties agree otherwise, of claims more than $15,000; panel determination is admissible at any later trial	§34.18.10.23 Medical review panel's testimony may qualify as expert testimony to establish prima facie	§16.9(5).5.1 (1975) Plaintiff's attorney fees may not exceed 15% of any award that is made from PCF (covers portion of an award that exceeds $100,000)	Indiana Supreme Court upheld constitutionality of statute of limitations, but established an exception where medical condition prevented discovery in *Martin v. Richey*, 711 N.E.2d 1273, 1279 (1999); original 1975 pretrial screening panel, limits on damage awards, and statute of limitation provisions upheld as constitutional in *Johnson v. St. Vincent Hospital*, 404 N.E. 2d 585 (1980); *St. Anthony Medical v. Smith*, no 37A04.9010 CV.460, Ind. App. Ct. May 28, 1992,; *Bova v. J.H. Roig, M.D.*, no. 56A03.9110.CV.313, Ind. App. Ct., 1st Dist., December 7, 1992

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Iowa	§614.1(9) (1997) 2 years from reasonable discovery but not more than 6 years from injury unless foreign object; minors under age 8: until age 10 or same as adults, whichever is later; mentally ill: extends to 1 year from removal of disability		§147.136 (1975) Mandatory offset of collateral sources	§668.3 (1987) Discretionary court-ordered periodic payment of future damages	§679A.1 (1981) Written arbitration agreement valid and irrevocable	§147.139 Qualifications of the expert must relate directly to problem at issue	§147.138 (1975) Court may review fees in any personal injury or wrongful death action against specified health care providers or hospitals	Eight Circuit upheld constitutionality of original 1945 statute of limitation in *Fitz v. Dolyak*, 712 F. 2d 330 (1983)
Kansas	§60.513.7(c) (1965) 2 years from act or reasonable discovery by not more than 4 years after injury; incompetent: 1 year from removal, but no more than 8 years from act	§60.3702 (1994) In any civil action, punitive damages limited to lesser of defendant's highest gross income for prior 5 years or $5 million; if profitability of misconduct exceeds cap, court may award 1.5 times profit instead; judge determines punitive damage; punitive damages unavailable in wrongful death cases	§60.3801-3807 (1992) Collateral sources admitted where plaintiff claims $150,000 or more in damages		§65.4901 (1976) Voluntary submission to medical screening panel upon request of party; §60.3501-3509 (1987) decisions admissible at any subsequent trial	§60.3412 50% of the expert's professional time over preceding 2 years must have been devoted to clinical practice		Kansas Supreme Court upheld constitutionality of statute of limitations in *Stephens v. Snyder Clinic Association*, 631 P.2d 222 (1981); collateral source rule ruled unconstitutional in *Thompson v. KFB Insurance Company*, No. 68,452 (1993), Ks. Sup. Ct; earlier discretionary offset (1985.1988: 60.3403) that applied only to medical liability actions struck down in *Farley v. Engleken, 740 P.2d 1058 (1987)*; 1965 cap on damage awards and periodic payment provision found unconstitutional in *Kansas Malpractice Victims v. Bell*, 757 P.2d 251 (1988)
Kentucky	§413.140 (1974) 1 year from act or reasonable discovery, but not more than 5 years after act; minor and unsound mind: statute runs when disability lifted		§411.188.3 (1988) Discretionary offset of collateral sources except life insurance		§417.050 (1984) Written arbitration agreements enforceable and irrevocable			Kentucky Supreme Court ruled unconstitutional 5 year statute of limitations in *McCollum v. Sisters of Charity of Nazareth Health Corp.*, 799 S.W.2d 15 (1990); collateral source rule overturned in *O'Bryan v. Hedgespeth*, 892 S.W.2d 571 (1995)
Louisiana	§9.5628 (1975, 1987) 1 year from act or date of discovery, but no later than 3 years from date of injury; applies regardless of minority or disability; Civ. Code §2315.2 wrongful death: 1 year from death	$100,000 liability limit for qualified health care providers; punitive damages not recoverable, except in certain situations				§40.122.47 Medical review panel's report considered expert testimony		Appellate Court upheld the constitutionality of statute of limitations in *Valentine v. Thomas*, 433 So. 2d 289 (1983); Louisiana Supreme Court upheld the constitutionality of limits on damage awards in *Williams v. Kushner*, *slip. Op.*, 88.C.1153, 88.C.1188 (September 12, 1989), *hr'g*. denied, 549 So. 2d 294 (1989), *Butler v. Flint Goodrich Hospital of Dillard University*, Supreme Court of Louisiana, no. 92cc 0559, (4th Circuit), October 19, 1992; 1976 pretrial screening panel provision upheld in *Everett v. Goldman*, 359 So. 2d 1256 (1978).

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Maine	§24.2902 (1977) 3 years from cause of action; 6 years after accrual for minors or within 3 years of minority, whichever is first; foreign objects: accrue from reasonable discovery; incompetence: accrue upon lifting of disability	§18A.2.804 (1999, 1990) For wrongful death cases, non-economic damages limited to $400,000 and punitive damages limited to $75,000	§24.2906 (1990) Mandatory offset of collateral sources that have not exercised subrogation rights within 10 days after a verdict for the plaintiff	§24.2951 (1985) Mandatory periodic payments of future economic damages exceeding $250,000 at the request of a party	§24.2851-59 (1990, 1986-1989) Mandatory submission of medical injury claims to a "pre-litigation screening and mediation panel" except where all parties have agreed to bypass; any findings unanimous and unfavorable to the claimant as to both negligence and causation are admissible at any subsequent trial; for claims after January 1, 1991, panel's discovery is deemed court discovery at any subsequent trial		§24.2961 (1985-1987) Sliding scale fees may not exceed: third of first $100,000; 25% of next $200,000 and 20% of damages that exceed $200,000; for purpose of rule, future damages are to be reduced to lump-sum value	
Maryland	Cts. & Jud. Proc. §5.109 (1975) 5 years from act or 3 years from discovery, whichever is earlier; minors: statute begins at age 11; excepts reproductive system damage or foreign object injury; Cts. & Jud. Proc. §3.904 (1995) wrongful death: must be filed with 3 years of death	Cts. & Jud. Proc. §11.108 (1986, 1994) In any action for damages for personal injury accruing after October 1, 1994, $500,000 cap on non-economic damages; increased $15,000 every subsequent October; separate cap for each "direct victim"; wrongful death cases may not exceed 150% of cap		Cts. & Jud. Proc. §11.109 (1986) Discretionary periodic payment of future economic damages	Cts. & Jud. §3.2A.03-06 (1995) Discretionary submission of claims to a "health claims arbitration panel"; panel's decision on fault is "presumed to be correct" and its award is admissible as evidence at any subsequent trail; rejecting party liable to other for costs if verdict less favorable than findings	§3.2A.04 (1997) Within 90 days of filing, claimant must file certificate of expert consultation	Cts. & Jud. Proc. §3.2A.07 (1976) Court or pretrial screening panel will review disputed fees in medical injury actions	Damage award cap on non-economic damages ruled constitutional in *Murphy v. Edmonds*, 325 Md. 342, 601 A.2d 102 (1992)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Massachusetts	§§231.60D; 260.4, 7 (1986) 3 years from date of injury, but not more than 7 years from injury unless foreign object; minors: before age 6 until age 9; tolled for disability	§231,60H (1986) $500,000 cap for non-economic damages, with certain exceptions; if the total amount of general damages from a single occurrence for all plaintiffs exceeds $500,000, then the amount of such damages recoverable by each plaintiff will be reduced to a percentage of $500,000 proportionate to that plaintiff's share of the total amount	§231.60G (1986) Mandatory offset determined by the court		§231.608 (1975) Mandatory submission or medical injury claims to a "medical malpractice tribunal"; decision admissible at any subsequent trial; if tribunal finds against claimant, claimant must post $6,000 (or greater) bond for defendants costs if unsuccessful		§231.601 (1986) Sliding scale fees may not exceed: 40% of first $150,000, 33.33% of next $150,000, 30% of next $200,000 and 25% of damages that exceed $500,000; further limits if claimants recovery insufficient to pay medical expenses	Massachusetts Supreme Judicial Court upheld the constitutionality of pretrial screening panel requirement in *Paro v. Longwood Hospital*, 369 N.E. 2d 993 (Mass. 1977)
Michigan	600.5838a, 5851(1846-1986) 2 years from injury or 6 months from reasonable discoverability, whichever is later, not to exceed 6 years; 6 years tolled for fraud or reproductive systems; disabled plaintiff: 1 year after injury except in cases of reproductive injury; foreign object: 6 months; minors under age 8: 6 years from date of occurrence or age 10, whichever is later (if action brought after 10th birthday, must be within the 6 year limit)	§600.1483 (1986) After April 1, 1994, $280,000 cap on noneconomic damages, adjusted annually for inflation; $500,000 cap for non-economic damages applies to certain other circumstances	§600.6303 (1986) Mandatory offset of collateral sources, except life insurance, admissible after a verdict for plaintiff	§600.5056 (1975) third of a medical malpractice arbitration award, unless parties stipulate awards in excess of $50,000, to be paid lump sum; §600.6307 (1986) mandatory periodic payment of future economic damages excluding future medical, other health care costs and collateral source benefits; future non-economic damages reduced to gross percent cash value	§600.4903,15, 17, 21 (1987) Mandatory review by medication panel; party rejecting panel's evaluation must pay opposing party's actual cost unless verdict more favorable than panel; §600.2912g (1975) parties may enter into binding arbitration if total damages claimed are less than $75,000	§600.2912 Expert must be a licensed health professional, practice in a similar specialty, be board certified (if required on specialty), during the year preceding action had clinical or academic experience in specialty; certificate of consultation must be filed	Mich. Court Rules 8.121(b) (1981) Maximum contingency fee for a personal injury action is third of the amount recovered	
Minnesota	§541.07 (1935, 1982) 2 years from injury or termination of treatment; tolled for insanity; infant's claim must be asserted within 7 years from injury or 1 year after age of majority		§548.36 (1986) Mandatory offset of collateral sources by court if defendant brings in evidence of payments made to plaintiff	§549.25 (1988) Discretionary periodic payment of future damages in excess of $100,000		§145.682 (1989) Claimant must file an affidavit stating that an expert has been consulted		Eighth Circuit has upheld the constitutionality of the statute of limitation in *Jewson v. Mayo Clinic*, 691 F. 2d 405 (1982)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Mississippi	§15.1.36 (1976) 2 years from act or reasonable discovery, within 7 years after the act; mentally incompetent plaintiffs: 2 years after disability ceases; minors under 6: 2 years after age 6 or death, whichever is first; tolled for insanity					§11.1.61 (1990) Expert witness must be licensed physician		
Missouri	§516.105 (1976) 2 years from act; foreign object: 2 years from discovery; in no event longer than 10 years from act or 10 years from minor's 20th birthday, whichever is later; minor under 8: until age 20	§538.210 (1986) Cap on non-economic damages adjusted annually for inflation; approximately $500,000 in 1997		§538.220 (1986) Mandatory periodic payment of future damages over $100,000 at the request of party		§538.225 Affidavit of expert consultation must be filed within 90 of filing of filing action		Supreme Court of Missouri upheld constitutionality of statute of limitation in *Ross v. Kansas City Gen. Hosp. & Med. Ct.*, 608 S.W. 2d 397 (1980); statute of limitation from minors 12 and older ruled unconstitutional in *Strahler v. St. Luke's Hospital*, 706 S.W.2d 7 (1986); limit on damage awards upheld in *Adams v. Childrens Mercy Hospital*, no. 73 867, Mo. Sup. Ct., (1991); pretrial screening panel provision overturned in *State ex rel. Cardinal Glennin Memorial Hospital v. Geartner*, 583 S.W. 2d 107 (Mo. Banc. 1979)
Montana	§27.2.205 (1971) 3 years from injury or discovery; in no event more than 5 years from act; tolled against a potential plaintiff where there has been a failure of disclosure of the act; minors under age 4: 3 years of age 8 or death, whichever occurs first	§25.9.411 (1995) court to impose a $250,000 limit any jury award for non-economic damages, for causes of action arising as of Oct. 1, 1995	§27.1.308 (1987) Mandatory offset of collateral sources by judge for awards greater than $50,000, in bodily injury and death cases	§25.9.4.3 (1995) Mandatory periodic payment at the request of party for awards in excess of $50,000, as of Oct. 1, 1995; in case of death, payments property of estate	§27.6.701 (1977) Mandatory review by Medical Legal Panel for actions not subject to valid arbitration agreement; panel report neither binding nor admissible at trial			Montana Supreme Court upheld the constitutionality of the pretrial screening panel statute in *Linder v. Smith*, 629 P.2d 1187 (1981)
Nebraska	§§25.222; 44.2828 (1976, 1996) 2 years from act or 1 year from reasonable discovery, but no more than 10 years after date of act; §25.213 under 21 or mentally disabled: statute runs from removal; §30.810 wrongful death: 2 years from death	§44.2825 (1976, 1986) $1 million limit on recoveries against health care providers qualifying for state-sponsored excess insurance; fundamental rule of Nebraska law prohibits punitive, vindictive, or exemplary damages	§44.2819 (1976) Non-refundable medical reimbursement insurance benefits credited against judgement, in certain actions		§44.2840-1 (1976) Mandatory review of medical injury claims except where plaintiff affirmatively waives his right to panel hearing; the panel report is admissible in any subsequent trial		§44.976 Court review for reasonableness of attorney fees in cases against health care providers	Nebraska Supreme Court upheld the constitutionality of the limit on damage awards, collateral source rule and pretrial screening panel requirement in *Prendergast v. Nelson*, 256 N.W. 2d 657 (1977)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Nevada	§41A.097 (1985-1989) 4 years from injury or 2 years from reasonable discovery, whichever is first; tolled for concealment; minors: statute runs until age 10 for brain damage or birth defects; if sterility alleged, statute runs 2 years after discovery; tolled for insanity or minors ward of state	§42.005 (1996) $300,000 or 3 times compensatory damages cap on punitive damages, only awarded for fraud, oppression, or malice	§42.020 Damages against health care providers reduced by amount of any prior payment by health care provider to the claimant; mandatory offset		§41A.003-069 (1985) Mandatory submission of claims to pretrial screening panel; decision and findings of panel concerning specific complaint at issue in a subsequent trial are admissible in court; unfavorable panel ruling makes claimant responsible for defendant's court cost, if loses at trial	§41A.097 (1996) Claimants must offer "expert medical testimony" showing a deviation from the standard of care		
New Hampshire	§507.C:4 2 year limit specific to medical malpractice found unconstitutional; §§508:4,8 (1986) 3 years from injury or reasonable discovery; infant or incompetents: 2 years from removal of disability	§507.C:7 (1977) $250,000 cap on non-economic damages; §556:13 $50,000 cap on wrongful death damages and restricted to immediate or dependent family members; after 1998, wrongful death cap raised to $150,000 and restricted to surviving spouse; §507:16 punitive damages prohibited	§507.C:7(I) (1977) Abolishes collateral source rule in medical malpractice cases	§524:6.a (1997) Periodic payment awarded at court discretion		§507.E.2 (1997) Claimants must provide expert testimony to support their claims	§508:4.e (1986) Fees for actions resulting in settlement or judgement of $200,000 or more shall be subject to court approval	New Hampshire Supreme Court struck down as unconstitutional the limit on non-economic damage awards, mandatory offset of collateral sources, and earlier provisions for discretionary award of periodic payment of future damages and attorney fees in *Carson v. Maurer*, 424 A. 2d 825 (1980); $875,000 limit on non-economic damages found unconstitutional in *Brannigan v. Usitalo*, no. 90.377, N.H. Sup. Ct. March 13, 1991
New Jersey	§2A:14.2, 14.23 (1987) 2 years from accrual of claim or discovery; under 21 or insane: runs upon removal; wrongful death: 2 years from death, 6 months after the death is not computed as part of the time period	§2A:15.5.14(b) (1997) punitive damages cap of $350,000 or 5 times compensatory damages, whichever is greater	§2A:15.97 (1987) Mandatory offset of collateral sources, excluding workers' compensation or life insurance, admissible at trial and deductible from any verdict for plaintiff		§4:21A.1-8 (1985) Voluntary arbitration of medical claims by written agreement, if claim under $20,000	§2A.53A.27 Affidavit of consultation of expert must be filed within 60 days of filing action	Court Rules §1:2107 (1976) Sliding scale fees may not exceed third of first $500,000, 30% of second $500,000, 25% of third $500,000 and 20% of fourth $500,000; 25% cap for a minor or an incompetent plaintiff	New Jersey Supreme Court upheld the constitutionality of a 1978 pretrial screening panel statute in *Perna v. Pirozzi*, 457 A.2d 431 (1983)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
New Mexico	§41.5.13, 22 (1976) 3 years from injury; minors under 6: until age 9 to file suit; applies to all persons regardless of minority or disability; the statute is tolled upon submission to hearing panel and shall not run until 30 days after panel final decision	§41.5.6-7 (1976) $600,000 ($500,000 for acts prior to April 1995) cap to all damages, excluding punitive damages and medical care and related costs; health care providers not liable for any amount over $100,000; future medical expenses not be awarded as monetary damages		§41.5.7 (1976) Mandatory periodic payment of damages for future medical care up to $200,000, after which patient's compensation fund must pay	§41.5.14-20 (1976) Mandatory submission of medical injury claims to a hearing panel; panel report is not admissible at any subsequent trial			
New York	CVP §214.a (1975) 2 1/2 years from injury or from last treatment where there is continuous treatment for condition giving rise to claim; foreign object: 1 year from discovery; incompetence tolls statute for maximum 10 years		Civ. Prac. §4545 (1981) Mandatory offset of collateral sources made by the court	Civ. Prac. §5031-5039 (1985) Mandatory periodic payment of future damages in excess of $250,000; parties may agree to lump sum payment; pain and suffering damages paid within a period no longer than 10 years	CPLR §3045 (1991) Defendant may concede liability if plaintiff agrees to arbitrate; if plaintiff refuses, defendant's concession of liability cannot be used for any other purpose; Public Health §4406.2 HMOs can put arbitration clauses in contracts, but not as a condition of joining	§3012.A Certificate of consultation of expert must be filed within 90 days of filing complaint	Jud. §474a (1985) Sliding scale fees may not exceed 30% of first $250,000, 25% of second $250,000, 20% of next $500,000, 15% of next $250,000 and 10% over $1.25 million	New York's highest court upheld the constitutionality of a pretrial screening panel statute in *Treyball v. Clark*, 483 N.E. 2d 1136 (N.Y. 1985)
North Carolina	§1.15 (1979) 3 years from act or 1 year from reasonable discovery, but not more than 4 years after injury; foreign object: 1 year from discovery, but not more than 10 years from last act; wrongful death: 2 years from death	§1D.25 (1995) Punitive damages cap of $250,000 or 3 times compensatory damages, whichever is greater			§7A.38.1 (1997) Mandatory mediation	§90.21.12 (1990) Expert must testify to community standard of care; §8C.1 Rule 702 expert must be licensed		North Carolina Court of Appeals upheld the constitutionality of the statute of limitations in *Roberts v. Durham County Hospital Corp.*, 289 S.E. 2d 875 (N.C. App. 1982)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
North Dakota	§§28.01.18, 25 (1975) 2 years from act or reasonable discovery, but not more than 6 years after act, unless concealed by fraudulent conduct of defendant; disability, except minority, tolls statute for 5 years, in no case after 1 year from removal of disability or 6 years total; minors: 12 years	§32.42.02 (1995) $500,000 cap on non-economic damages; §32.03.2.08 economic damage awards in excess of $250,000 subject to court review for reasonableness	§32.03.2.06 (1987) Discretionary offset of collateral sources, excluding life insurance, death or retirement benefits or any insurance purchased by recovering party	§32.03.2.09 (1987) Discretionary periodic payment of future economic damages for continuing institutional or custodial care for a period of more than two years; adequacy of payments subject to continuing court review	§32.42.03 (1996) Attorneys must disclose alternative dispute resolutions option; good faith effort to resolve dispute required	§28.01.46 A claimant is required to obtain supportive expert opinion within 3 months of filing complaint		A $300,000 limit on medical liability awards and an earlier discretionary offset in cases involving $100,000 or more were struck down as unconstitutional in *Arneson v. Olson*, 270 N.W. 2d 125 (N.D. 1978)
Ohio	§2305.11 B(1) (1990) 1 year after reasonable discovery; if plaintiff gives written notice before the 1 year expires, suit may be brought within 180 days of the notice; persons with legal disability must bring suit within 4 years after occurrence; for actions accruing as of Jan. 27, 1997, 6 year statute of repose; minor, unsound mind, or imprisoned: tolled until disability removed; wrongful death: 2 years from death	§2323.54 (1997) as of Jan. 27, 1997, non-economic cap of $250,000 or 3 times economic damages up to $500,000, whichever is greater; for more serious loss, $1 million or $35,000 times remaining life expectancy; §2315.21 (1997) punitive damages cap or $100,000 or 3 times compensatory damages, except for defendants that employ more than 25 persons, for whom cap is $250,000 or 3 times compensatory damages; prohibits punitive damages if defendant already paid amount of cap of punitive damages in another case	§23 (1975) Evidence of collateral sources in medical actions, except for insurance benefits paid for by plaintiff or employer (but including workers' compensation), admissible at trial	§2323.57 (1987) Mandatory periodic payment of future damages over $200,000 at request of party	§2711.21 (1975, 1987) Voluntary submission of medical injury claims to an "arbitration board" upon agreement of all parties; decision is not admissible at any subsequent trial; prior to 1987 amendment, submission was mandatory and results were admissible	§2743.43 (1975) Expert testimony limited to licensed physician or surgeon who devotes 3/4 time to active clinical practice or teaching; §2305.01.1 claimant must file certificate of consultation with expert		Ohio Supreme Court struck down a $200,000 limit on general damages in *Morris v. Savoy*, No. 89.1807, Ohio Sup. Ct. (1991); a $250,000 limit on non-economic damages overturned in *Gladon v. Greater Cleveland Regional Transit Authority*, No. 64029, Ohio App. Ct., 8th App. Desk., Cuyahoga County (1994); the 8th District twice upheld the collateral source rule in *Morris, et al. v. Savoy*, No. 89.1807, Ohio Sup. Ct. (1991) and *Charles William May v. Tandy Corp., et al.*, No. 62679, Ohio App. Ct., 8th Dist., Cuyahoga Co., (1993) and *Gladon v. Greater Cleveland Regional Transit Authority*, No. 64029, Ohio App. Ct., 8th App. Dist., Cuyahoga County (1994); the Court of Appeals of Ohio (11th District) struck down collateral source rule in *Schenk v. The Cleveland Electric Illuminating Company*, No. 92.L.161 (1994); Ohio Supreme Court upheld the 1975 pretrial screening panel statute in *Beatty v. Akron City Hospital*, 424 N.E. 2d 586 (1981)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Oklahoma	§§76.18 (1987) 2 years from reasonable discovery; after 3 years from act, recovery limited to past and future actual medical and surgical expenses; §12.96 (1988) minors under 12: 7 years; minors over 12: 1 year after attaining majority but in no event less than 2 years from injury; incompetents: 7 years from injury unless adjudged incompetent, then 1 year after such adjudication, but in no event less than 2 years from injury	§23.9.1 (1998) $100,000 cap on punitive damages for reckless disregard; punitive damages cap of $500,000, 2 times compensatory damages, or benefit derived by defendant from his conduct for intentional and malicious acts (waived in certain circumstances); discretionary waiver of damages by court if defendant already paid punitive damages for same action	Discretionary offset of collateral sources				§5.7 (1953) Maximum percentage: fee may not exceed 50% of net judgement	Oklahoma Supreme Court upheld 2 year statute of limitations as constitutional in *McCarroll v. Doctors General Hospital*, 664 P. 2d 382 (Okla. 1983); 3 year statute of repose on all damages other than past and future medical and surgical expenses ruled unconstitutional in *Wofford v. Davis*, 764 P.2d 161 (Okla. 1988); earlier limit on damage awards struck down in *Reynolds v. Porter*, 760 P.2d 816 (Okla. 1988)
Oregon	§§12.110;160 (1988) 2 years from reasonable discovery; but not more than 5 years from act; fraud: 2 years from reasonable discovery; minors or insane: 5 years from accrual or 1 year after disability ceases; wrongful death: 3 years from death or reasonable discovery	§18.540, 560 (1987) $500,000 cap on non-economic damages (overturned except with regard to wrongful death); §18.550 (1989) no punitive damages awarded against licensed physician unless malice is shown; 60% of punitive damages paid to Criminal Injuries Compensation Account	§18.580 (1987) Discretionary offset after judgement of collateral sources by court, except benefits plaintiff must repay, life insurance, retirement, disability, pension plans or social security				§18.540 Attorneys fees from punitive damages may not exceed half the claimant's 40%	Oregon Supreme Court ruled non-economic damages cap unconstitutional, except in wrongful death suits, in *Lakin v. Senco Products, Inc.*, 329 Or. 62,_P.2_, 1999 WL 498088 (July 15, 1999)
Pennsylvania	§42.5524 (1975) 2 years from injury or reasonable discovery; §42.5533 minor: 2 years after age of majority	§40.1301.812.A(g) (1997) Effective Jan. 25, 1997, punitive damages cap of $100,000 or 2 times compensatory damages; members of Medical Professional Liability Catastrophe Loss Fund, in effect, subject to limited liability			§40.1301.825A (1975) Mandatory "conciliation hearing", which may be a settlement conference or mediation as the parties prefer	§1301.821.A Attorney's signature on a complaint certifies that attorney has consulted an expert who will attest to position		Pennsylvania Supreme Court found a statute providing for a mandatory offset of collateral sources in medical liability actions unconstitutional by the in *Mattes v. Thompson*, 421 A. 2d 190 (Pa. 1980); earlier mandatory pretrial screening panel struck down in *Mattes v. Thompson*, 421 A. 2d 190 (Pa. 1980); panels may exist as long as participation is voluntary and the outcome is not binding; attorney fee limits struck down in *Heller v. Frankston*, 504 Pa. 528, 475 A.2d 1291 (1984)
Rhode Island	§§9.1.14.1; 10.7.2 (1976, 1988) 3 years from injury, death or reasonable discovery; minors and incompetents: 3 years from removal of disability	§9.1.8 (1997) Punitive damages not recoverable against executor or administrator of an estate; §9.19.41 (1997) $100,000 minimum recovery in any wrongful death action	§9.19.34.1 (1986) Mandatory offset by court in medical liability actions, if evidence is admitted	§9.21.12-13 (1986) Mandatory conference on periodic payment where judgment exceeds $150,000		§9.19.41 (1997) expert must have training/ education to qualify as an expert		Pretrial screening panels were found unconstitutional in *Boucher v. Sayeed*, 459 A. 2d 87 (R.I. 1983)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
South Carolina	§15.35.45, 15.3.40 (1977-1988) 3 years from injury or reasonable discovery, but not more than 6 years after act; foreign object: 2 years from discovery; minors: tolled, but no more than 7 years from act or 1 year from majority; tolled for disability, up to 5 years or 1 year after disability ceases							
South Dakota	§15.2.14.1, 221 (1984) 2 years from injury; tolled for fraud or foreign object until end of treatment; tolled for minority for 3 years or until age 8 if under age 6; metal illness: tolls statute up to 5 years; 1 year from removal; wrongful death: 3 years from death	§21.3.11 (1985) $500,000 cap on non-economic damages; prior to 1985, cap on all damages of $1 million	§21.3.12 (1977) Discretionary offset in medical liability cases, except benefits that have a right if subrogation or were paid for by plaintiff	§21.3A.1-12 (1986-1988) Mandatory periodic payment of future damages in excess of $200,000 or past and future damages of $500,000, whichever is less; discretionary at the request of a party	§21.25B.1 (1976) Parties may agree to arbitrate for past and future services; revocable as to future services			The South Dakota Supreme Court rejected the discovery rule in *Alberts v. Giebink*, 299 N.W. 2d 454 (1980); law reducing statute of limitation for minors ruled unconstitutional in *Lyons v. Lederle Laboratories*, 440 N.W.2d 769 (S.S. 1989); $500,000 cap on non-economic damages ruled unconstitutional, reviving prior statute, in *Knowles v. U.S.*, 544 N.W.2d 183 (S.D. 1996)
Tennessee	§29.26.116 (1975) 1 year from discovery, but no more than 3 years from act unless foreign object; foreign object: 1 year from discovery; under 18 or unsound mind: 1 year from removal		§29.26.119 (1975) Mandatory offset except for assets purchased by plaintiff or private insurance		§29.5.101 All causes of action may be submitted to the decision of arbitrators except where 1 of the parties is an infant or a person of unsound mind	§29.26.115(b) (1975) Expert witness must be licensed in Tennessee or contiguous state and practice for one year preceding date of injury	§29.26.120 (1975) Plaintiff's attorney fees in a medical injury suit shall not exceed third of all damages awarded	Tennessee Supreme Court upheld the constitutionality of statute of limitation in *Harrison v. Schrader*, 569 S.W. 2d 822 (Tenn. 1982)
Texas	Civ. §4590i.10.01 (1977) 2 years from occurrence (discovery); minors under 12: until age 14; otherwise applies to all regardless of minority or disability	Civ. §4509.11.02-04 (1977) approximately $1.3 million cap on wrongful death damages, adjusted annually for inflation; Civ. Prac. & Rem. §41.008 (1995) punitive damages cap as of Sept. 1, 1995 of 2 times economic damages, plus non-economic damages (not to exceed $750,000), or $200,000, whichever is greater, with certain exclusions				§14.01 Expert must have experience relating to complaint; Tex. Rev. Civ. Stat. Ann. 4590I, §13.01 plaintiff must post file on expert w/in 90 days of filing		The Texas Supreme Court struck down limit on damage awards as unconstitutional in *Lucas v. United States*, 757 S.W. 2d 687 (Tex. 1988); limit subsequently found constitutional only in wrongful death cases in *Rose v. Doctors Hosp.*, 801 S.W.2d 841 (Tex. 1990)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Utah	§78.14.14 (1985) 2 years from discovery but not more than 4 years from act; foreign object or fraud: 1 year from discovery, applies to all persons regardless of minority or disability	§78.14.7.1 (1986) $250,000 cap for non-economic losses	§78.14.4.5 (1985) Mandatory offset by court except for benefits where subrogation rights exist	§78.14.9(5) (1986) Mandatory periodic payment of future damages that exceed $100,000, exclusive of attorneys' fees and costs	§78.14.8-16 (1985) Decision of pre-litigation panel may be considered binding arbitration upon written agreement of parties; mandatory submission of claims to panel; panel recommendations not admissible at subsequent trial		§78.14.7(5) (1985) Contingency fee shall not exceed third of award	Utah Supreme Court ruled unconstitutional the minority provision of the statute of limitation in *Lee v. Dr. Lynn Craufin*; *Griffith v. Dr. J. Dallas Van Wagoner*, nos. 20995, 21063, 90095, Utah Supreme Court, Nov. 30, 1993; this reversed an earlier decision in *Allen v. International Health Care, Inc.*, 635 p. 2d 30 (1981)
Vermont	§12.521, 551 (1977) 3 years from injury or 2 years from reasonable discovery, but no more than 7 years from act, excluding concealment and foreign objects; foreign object: 2 years from discovery; tolled until removal of disability				§12.7002 (1995) Mandatory submission to pretrial arbitration panel; findings subject to appeal unless parties agree to binding arbitration			
Virginia	§8.01.229, 243 (1959, 1987) 2 years from injury, but not more than 10 years from act; foreign object or fraud: 1 year from reasonable discovery; infants: 5 years from date of accrual of cause of action; for claims accruing on or after July 1, 1987, minors under 8: age 10; age 8 or older: 2 years after last treatment unless; minors who were 10 or older on or before July 1, 1987: 2 years from that date to bring an action	§8.01.581.15 (1976-1983) $1.5 million cap on recovery damages for bodily injury or death, shall increase on July 1, 2000 by $50,000 and every July 1 after that until 2007 and 2008 when the final increases will be $75,000 per year; cap applies for each injury, regardless of number of theories or defendants; §8.01.38.1 (1992) $350,000 cap on punitive damages		§8.01.424 Periodic payment of awards permitted, if reviewed by court and secured by bond or insurance	§8.01.581.2, 8 (1997) Review by pretrial panel by request; findings non-binding; testimony of panel members, except chair, admissible; §8.01.581.12 (1997) parties permitted to agree in advance of treatment to binding arbitration, with period of patient withdraw	§8.01.581.20 (1992) Claims must be supported by expert testimony; physicians must have had an active clinical practice in the field about which he will testify within year of incident		Virginia Supreme Court upheld constitutionality of a prior $750,000 cap on damage awards in *Etheridge v. Medical Center Hospitals*, 376 S.E. 2d 525 (Va. 1989); pretrial screening panel statute upheld as constitutionality in *Speet v. Bauaj*, 377 S.E. 2d 397 (Va. 1989)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Washington	§4.16.350 (1971, 1988) 3 years from injury or 1 year from discovery, whichever is later, but no more than 8 years after act; fraud, concealment or minority toll statute; foreign object: 1 year from discovery; wrongful death: 3 years from death	§4.56.250 (1986) Noneconomic damages in person injury suit may not exceed an amount determined by multiplying 0.43 by the average annual wage in state and by the life expectancy of the person incurring noneconomic damages; a plaintiff's life expectancy shall not be less than 15 years for the purpose of determining maximum noneconomic damages	§7.70.080 (1976) Information on collateral sources may be introduced except for insurance purchased by plaintiff or employer	§4.56.260 (1986) Mandatory periodic payments in personal injury actions of future economic damages of $100,000 or more			§7.70.070 (1976) In any medical injury the court shall determine the reasonableness of each party's attorney fees	Washington Appellate Court upheld constitutionality of statute of limitation on constitutional in *Duffy v. King Chiro. Practice Clinic*, 565 P.2d 435 (Wash. App. 1977); limit on damage awards struck down in *Sofie v. Fibreboard Corporation*, 771 P.2d 711 (Wash. 1989)
West Virginia	§55.7B.4 (1986) 2 years from injury or reasonable discovery, whichever occurs last; in no event longer than 10 years after injury; minors under 10: 2 years from injury or by age 12, whichever provides a longer period; statute tolled for any period during which fraud or concealment prevents discovery	§55.78.9 (1986) $1 million cap on non-economic damages; court must instruct jury				§55.75.7 (1986) Expert witness must be licensed physician and engaged in the same or substantially similar medical field as defendant		West Virginia Supreme Court upheld constitutionality of limit on damage awards in *Robinson v. Chaleston Area Medical Center*, no. 20109, W. Va. Sup. Ct. App., December 20, 1991
Wisconsin	§893.55, 56 (1979) 3 years from injury or 1 year from discovery, but not more than 5 years from act; foreign object: 1 year from discovery or 3 years from act, whichever is later; minors: by age 10 or standard provision, whichever is later	§893.55(4)(d) (1995) For acts as of May 25, 1995, $350,000 cap adjusted annually for inflation for non-economic damages, excluding wrongful death cases, which are limited to $500,000 for a child and $350,000 for an adult	§893.55(7) Effective May 25, 1995, collateral source information is admissible at trial	§655.015 (1986, 1995) For settlement or judgement for act occurring on or after May 25, 1995 in excess of $100,000, award paid into interest baring fund, from which periodic payments are made	§655.42, 442-5 (1985, 1989) Voluntary submission of medical injury claims to mediation panel; findings of panel inadmissible at subsequent court action		§655.013 (1986) Sliding scale may not exceed: third of first $1 million or 25% or first $1 million recovered if liability is stipulated within 180 days, and not later than 60 days before the first day of trial and 20% of any amount exceeding $1 million	The Wisconsin Supreme Court upheld the constitutionality of earlier statute of limitation in *Rod v. Farrell*, 291 N.W. 2d 568 (1980); earlier cap on non-economic damages ruled unconstitutional in *Jelenik v. The Saint Paul Fire and Casualty Insurance Company*, No. 92.1858, Wis. Sup. Ct., March 14, 1994; periodic payment awards upheld in *State ex re. Strykowski v. Wilkie*, 261 N.W. 2d 434 (Wis. 1978)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Payment of Awards	Pretrial Screening Panels	Expert Witness Rules[1]	Attorneys' Fees	Case History
Wyoming	§1.3.107, 1.38.102 (1977) 2 years from injury or reasonable discovery; minors: until age 8 or within 2 years, whichever is later; legal disability:1 year from removal; wrongful death: 2 years from death	Limits on damage awards prohibited by state constitution					Ct. Rules, Contingent Fee R. 5 (1997) Where recovery is $1 million or less: third if claim settled prior 60 days after filing, or 40% if settled after 60 days or judgement; 30% over $1 million	Wyoming Supreme Court struck down the 1986 pretrial screening panel statute requiring mandatory submission of all medical injury claims to a "medical review panel" in *Hoem v. Wyoming*, 756 P.2d 780 (Wyo. 1988)

Sources: National Conference of State Legislatures (June 2001)
McCullough, Campbell and Lane, *Summary of United State Medical Malpractice Law*
American Tort Reform Association (ATRA)

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